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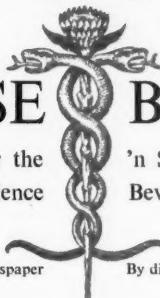
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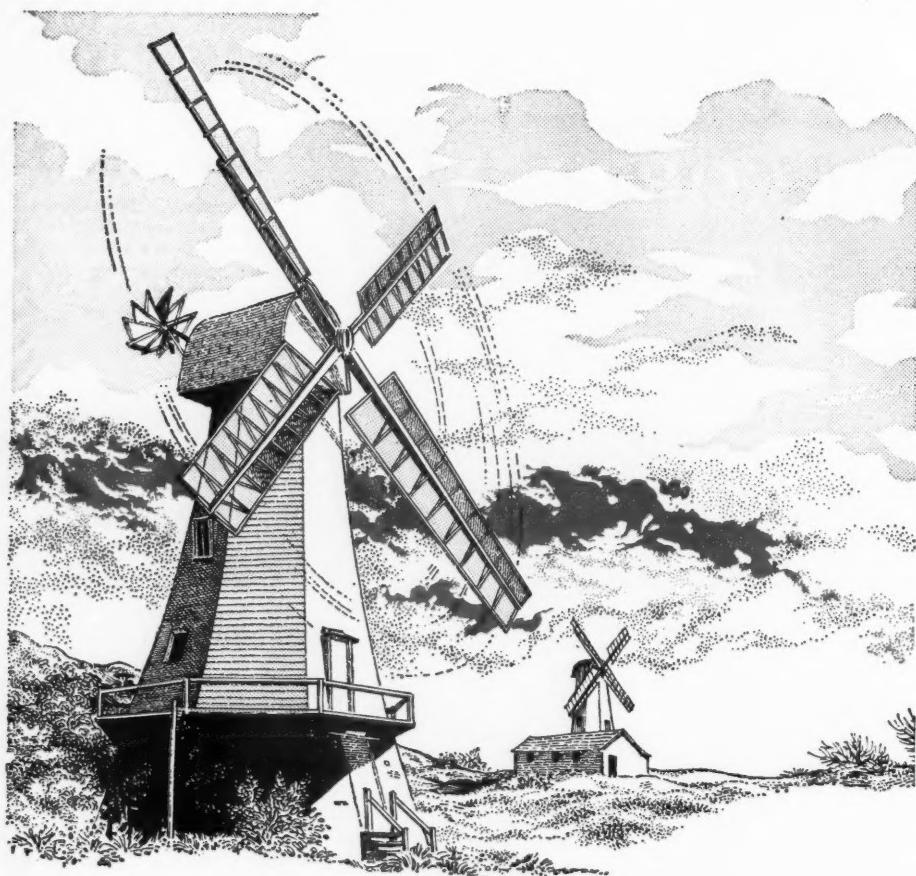
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No. 1

REDAKSIONEEL · EDITORIAL

HIDROCHLOORTIASIED

Hidrochloortiasied, 'n nuwe, kragtiger derivaat van chloortiasied, is onlangs in Kansas City beskryf deur dr. Karl H. Beyer, Onderpresident van die Merck Sharp & Dohme-navoringslaboratoriums, 'n afdeling van Merck & Co., Inc. Die nuwe verbinding is reeds beskikbaar gestel vir kliniese navorsing in die Verenigde State, en daar word verwag dat dit binnekort ook in Suid-Afrika beskikbaar gestel sal word.

Hidrochloortiasied is die gevolg van die byvoeging van 2 waterstofatome by die chloortiasied-molekule (Fig. 1). Dit is vir die eerste keer gesintetiseer deur dr. Frederick C. Novello by die navorsingslaboratoriums van Merck Sharp & Dohme in die Verenigde State.

Afgaande op beperkte kliniese proefnemings skyn dit asof hidrochloortiasied dieselfde biologiese effek en indikasies vir terapie as chloortiasied het. Laasgenoemde produk wat tans op 'n groot skaal dwarsdeur die wêreld gebruik word, is verwelkom as 'n hoogs belangrike vordering op die gebied van die behandeling van hartkwaal, drukverhoging, nier- en lewerkwaal, die toksemie van swanger-skap en vóórmaanstdond-spanning.

Hidrochloortiasied is nog in die kliniese navorsingstad, en veel werk sal gedoen moet word voordat die biologiese effek daarvan ten volle bekend is.

HYDROCHLOROTHIAZIDE

Hydrochlorothiazide, a new, more potent derivative of chlorothiazide, was described recently in Kansas City by Dr. Karl H. Beyer, Vice-President of the Merck Sharp & Dohme Research Laboratories, division of Merck & Co., Inc. The new compound has been made available for clinical research in the United States and is expected also to be made available in South Africa shortly.

Hydrochlorothiazide represents the addition of 2 hydrogen atoms to the chlorothiazide molecule (Fig. 1). It was first synthesized by Dr. Frederick C. Novello at the Merck Sharp & Dohme Research Laboratories in the United States.

Based on limited clinical studies, hydrochlorothiazide appears to have the same biological effects and indications for therapy as chlorothiazide. The latter product, now used widely throughout the world, has been hailed as a major advance in the treatment of heart disease, hypertension, kidney and liver diseases, toxæmia of pregnancy and premenstrual tension.

Hydrochlorothiazide is still in the clinical research stage and much work remains to be done before its biological effects are fully known.

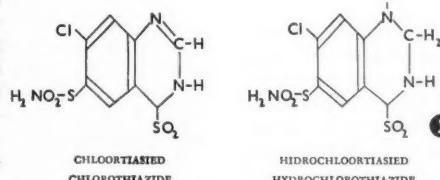


Fig. 1

Tydens uitgebreide gebruik by duisende pasiënte het chloortiasië die bewys gelewer dat dit buiten gewoon min neue-effekte tot gevolg het. Derhalwe sal die nuwe verbinding met groot sorg geëvalueer moet word om heeltemal seker te maak dat die verhoogde sterkte daarvan nie vergesel gaan van neue-effekte wat nie in die geval van chloortiasië teek gekom word nie.

Die ontdekking van chloortiasië het 'n nuwe uriendrywende middel van 'n unieke tipe beskikbaar gestel. Wat nog nie volkomme begryp word nie, is die versterkende uitwerking wat dit het op die bloeddrukverlagingseffek van senuknoooversperingsmiddels en ander preparate wat vir die behandeling van drukverhoging gebruik word.

Chlorothiazide has proved unusually free from side effects during extensive use in thousands of patients. Nevertheless, the new compound must be evaluated with extreme care to be sure that its increased potency is unaccompanied by side effects not encountered with chlorothiazide.

The discovery of chlorothiazide marked the introduction of a new, unique type of diuretic agent. Not yet fully understood is its potentiation of the blood pressure lowering effects of ganglionic blocking agents and other drugs used in the treatment of hypertension.

POST-HYPOGLYCAEMIC COMA

TWO CASE REPORTS

TERENCE E. LYNCH, M.B., B.C.H., D.P.M.*

Tara Hospital, Johannesburg

Cases of prolonged coma, termed post-hypoglycaemic coma, may occur as a complication of Sakel's insulin treatment in psychiatric practice. Similar cases have also been reported in diabetics receiving insulin.¹ The condition is also known as 'irreversible coma,' 'post-hypoglycaemic encephalopathy' and 'non-hypoglycaemic coma.' Goldman² emphasizes that the condition 'is an entity in itself and only related in a secondary sense to the hypoglycaemia.' It may be diagnosed when a patient in coma from insulin fails to regain consciousness in spite of adequate measures to restore the blood sugar level to normal. Wortis and Lambert³ point out that the over-prolongation of coma may be due to gastric retention of glucose solution given by nasal tube. Thus 'adequate measures to restore the blood sugar level' include the administration of glucose intravenously.

The pathogenesis of post-hypoglycaemic coma is unknown, but Lawrence *et al.*⁴ state that 'the main cause is considered to be failure of vital oxidative processes from lack of substrate glucose, probably reinforced by subsequent vasomotor disturbances.' Proctor and Easton⁵ discuss the relationship of blood sugar levels to consciousness and found little correlation in a case of post-hypoglycaemic coma.

An interesting finding is that occasionally there is dramatic improvement in the patients' mental condition when they do recover from the prolonged coma, but Lester⁶ states that such improvement is unusual. Wechsler⁷ cites

a case in which hypoglycaemic coma was intentionally prolonged for 10 hours with the idea of obtaining such improvement; post-hypoglycaemic coma lasting for 51 days developed and organic dementia was the end result.

The first case presented here showed marked initial improvement in the mental condition followed by a relapse a few months later. In the second case there was improvement in the original psychotic symptoms, but residual mental and physical impairment were present.

The incidence of the condition, reported by different authors, varies widely. Spencer,⁸ who gives a comprehensive review of the literature on the subject, quotes sources in which the incidence varied from 2.7% to 30.1% of cases treated.

CASE 1

A European female, aged 29 years, was admitted to hospital on 16 October 1950, under an urgency order. She had received electro-convulsive therapy from a private practitioner before admission.

On admission she lay on the floor and wept but suddenly she changed to laughing. She made grimaces and was restless and fidgety. She made a peculiar clawing movement with her right hand. She had difficulty in collecting her thoughts when questioned but her conversation was relevant and rational. She was correctly orientated in all spheres, her memory was good, intelligence average and she expressed no delusions and was not overtly hallucinated. She

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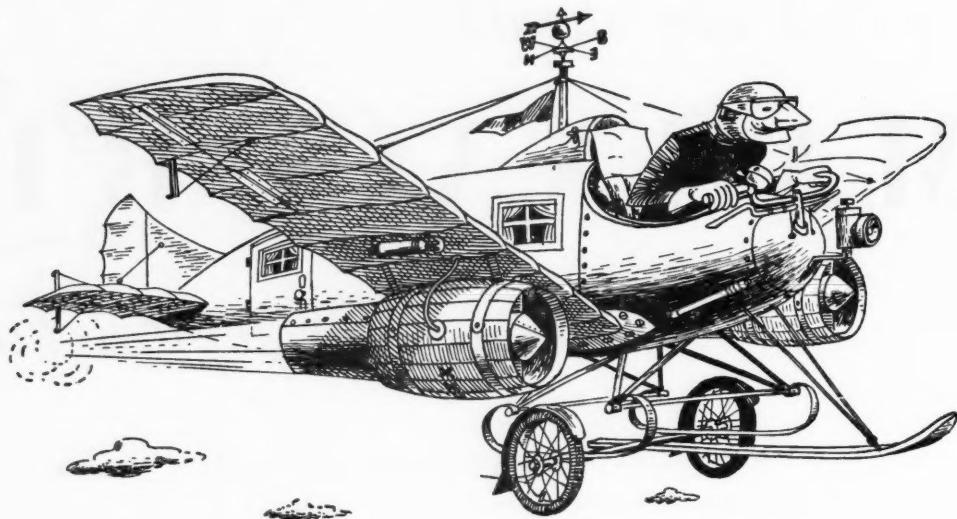
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admitted an attempt at suicide before admission. She complained of a sore throat which, she maintained, no one would ever be able to cure.

External strabismus and slight ptosis of the right eye were present. This condition was of long standing. It was noted that whenever her mental symptoms showed any exacerbation, this feature became more marked and at times she kept the eye tightly closed. She had hirsutes of the face and around the nipples. Apart from these points her physical state was normal.

Her mental condition improved and in November 1950 she went on leave from hospital at her parents' request. She was brought back in January 1951, with the report that she had again become uncontrollable at home. Her condition on re-admission was much the same as on her first admission.

Narco-analysis under intravenous Sodium Amytal led her to state that she had 'unjust thoughts' against her 'fellow men' and she spoke of having 'done a misdeed' some months before, but no details were given. There was no improvement in her condition and, in fact, she became very excitable and impulsive, her habits became faulty and she required frequent sedation. She was destructive, she made animal noises and exhibited stereotypy in speech.

A course of electro-convulsive therapy was given in February and March 1951. She improved sufficiently to be able to attend the occupational therapy centre, but soon relapsed. A second course of electro-convulsive therapy, in May 1951, gave only transient improvement.

At about this time she began to express ideas of influence saying that a 'bossie Dokter' had hypnotized her. She also had ideas of unreality and indications of depersonalization: 'Ek voel so 'n blank, as ek iets wil doen kom dit nie vanself nie.'

In view of her lack of response to electro-convulsive therapy and the deterioration in her mental state a course of insulin coma treatment was commenced in June 1951.

On the first day of treatment 40 units of insulin were given, this being rather a high initial dose. On the third day, having received 80 units of insulin, a spontaneous epileptic convulsion occurred. Seizures also took place on the sixth and eleventh days of treatment with 100 and 160 units of insulin respectively. The first coma occurred on the fourth day of treatment, which is relatively early in the course. This is a factor of possible prognostic significance for the development of post-hypoglycaemic coma later in the course of treatment.⁸

The patient's response to insulin was irregular, as evidenced by the fact that she would go into deep coma on one day and on the following day only have sopor with the same dose of insulin. She was restless during the induction stage and also during termination. For this reason a sedative was given at the same time as the insulin from the thirteenth day of treatment onwards. At first Sodium Phenobarbitone gr. 1½ was given but this was changed to Sodium Amytal gr. 3 on the 3 days of treatment before the development of the post-hypoglycaemic coma. A recent report by White *et al.*⁹ suggests that Sodium Amytal may be a causative factor in some cases of post-hypoglycaemic coma.

The coma dose of insulin had been stabilized at 160 units by the eleventh day of treatment. It was on the nineteenth day of treatment, after she had had her ninth coma, that the post-hypoglycaemic coma occurred. The clinical record of the latter is as follows:

29 June 1951. One hundred and sixty units of insulin were given at 6.45 a.m., Sodium Amytal gr. 3 at 7 a.m. and Atropine gr. 1/100 at 8.30 a.m. At 9.35 a.m. the patient went into coma and at 9.55 a.m. (20 minutes later) she was given glucose solution by stomach tube. She responded to this and was reported to be feeling comfortable about 30 minutes later. At 12.20 p.m. she was found to be comatose again. Another glucose feed by stomach tube was given but she failed to respond. Fifty c.c. of 50% glucose solution, 50 mg. of nicotinic acid and 3 c.c. of a vitamin B complex preparation containing thiamine hydrochloride, riboflavin and niacinamide, were immediately given intravenously, with no response. This was repeated at 1.25 p.m. and another stomach tube feed of glucose solution was given at 2 p.m., still with no response. It appears to be an unusual feature of the present case that the post-hypoglycaemic coma developed in an after-coma and did not directly follow on the therapeutic coma of the day.

The patient's temperature had risen to 103.2° F., the pulse was 130 beats per minute and the respirations were 36 per minute. The blood pressure was 140/74 mm. Hg. There were no signs of pulmonary pathology.

A further 50 c.c. of 50% glucose solution intravenously at 8 p.m. produced a slight response. She was given 4-hourly tube feeds of glucose solution throughout the night.

30 June 1951. The patient was still in coma. Her general condition was fairly good, there was no cyanosis, no local signs in the lungs and no indication of shock. Eight c.c. of 50%

glucose solution were given intravenously and 4-hourly tube feeds of glucose solution were continued throughout the day and night. There was no evidence of gastric retention of the feeds.

1 July 1951. The patient was still in coma. Her general condition remained good. Glucose solution was given during the day and nicotinic acid and thiamine hydrochloride were also administered. The coma became lighter, eye movements were present and she made licking movements with her tongue. She gave an impression similar to that in a case described by Spencer⁸ of 'deliberately willing herself to remain out of contact with reality.' It may be mentioned here that catatonic stupor is sometimes mentioned in the differential diagnosis of the condition. There was no pulmonary or sacral oedema.

2 July 1951. The patient was still in light coma. During the day she began to make some response to painful stimuli and her eye movements became purposeful. At 9 p.m. she spoke a few words. The coma had lasted for 80 hours.

A report on her cerebrospinal fluid was as follows:

Fluid clear and colourless with no coagulum. Pressure 160 mm. H₂O. Protein 30 mg. per 100 c.c.; chloride, 670 mg. per 100 c.c.; sugar 69 mg. per 100 c.c. There was one lymphocyte per c.mm.

On 3 July 1951 she was talking and able to take nourishment by mouth. However, she remained drowsy and listless but showed gradual improvement for another 7 days.

From 10 July onwards she made a slow uninterrupted recovery and by 23 July 1951 she was walking about and eating and sleeping well. She did not show any of her previous mental symptoms and had an amnesia for the early part of her stay in hospital. She did realize, however, that she had been mentally ill. She was now pleasant, friendly and cooperative. She was inclined to be over-anxious about trifles and was excessively grateful for medical attention.

She had weakness of both forearms and hands, more marked on the left side, where it presented the features of an ulnar paresis. There was also complete loss of sensation over the medial aspect of the left little finger.

On 18 August 1951 she went on leave from the hospital.

In February 1952 she was returned to hospital by her parents who stated that she had again become impossible to manage at home. The improvement in her mental condition had

lasted for about 4 months, after which her symptoms recurred and became progressively worse, leading to her re-admission. On physical examination at this time it was noted that the ulnar paresis had completely cleared up. Shortly after re-admission she again left hospital at her parents' request, after arrangements had been made for further treatment by a private practitioner.

CASE 2

A female aged 17 years was admitted to hospital on 25 March 1953, with a diagnosis of schizophrenia. Two months before she had become acutely ill with uncontrollable excitement, restlessness, delusions and aural hallucinations. She was treated by a private practitioner with electro-convulsive therapy and insulin coma (10 to day of admission) with a coma dose of 300 units of insulin. There had been some improvement in her condition.

On admission she stated that she felt everybody was following her and staring at her. She was convinced that she was her own grandmother and that her mother was her daughter and was dead. Her manner was silly and fatuous and her affect shallow and incongruous with her mental content. Physical examination showed no abnormalities.

The diagnosis of schizophrenia was confirmed and it was decided to continue with the insulin coma treatment she had been receiving. On 300 units the patient only attained a state of sopor or light coma and by 28 March 1953 the dose had been increased to 340 units, producing satisfactory coma. After 30 minutes of coma she was given a tube feed of glucose but failed to respond. She suddenly developed an acute pulmonary oedema; Atropine gr. 1/50 and morphine gr. 1/6 were given intravenously and oxygen administered. The pulmonary oedema cleared but the patient remained in a restless comatose condition, the temperature rose to 102° F., the pulse rate was 140 beats per minute and the respiratory rate 36 per minute. The blood sugar was maintained with 50% glucose solution at intervals, blood sugar estimates varying between 80–105 mg. per 100 ml; 25 units of ACTH and a massive dose of vitamin B₁ (800 mg.) were also given.

There was no response and the patient remained in coma until 12 April 1953, a total of 16 days. During this period the blood sugar was maintained at normal levels by tube feeding with occasional intravenous supplementation.

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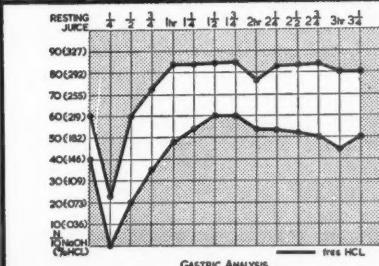
INDICATIONS: NULACIN tablets are indicated whenever neutralization of the acid gastric contents is required: in active and quiescent peptic ulcer, gastritis and other conditions of gastric hyperacidity.

Dosage: Beginning half-an-hour after food, a Nulacin tablet should be placed in the mouth between the cheek and the gum and allowed to dissolve.

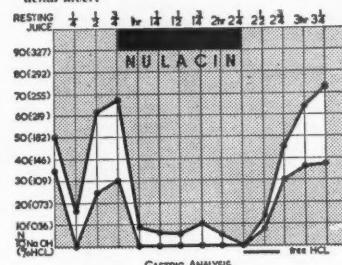
During the stage of ulcer activity, up to three tablets an hour may be required. During quiescent periods, for prophylaxis in peptic ulcer and for the relief of discomfort due to gastric hyperacidity, the dose of Nulacin is one or two tablets between meals.

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GASTRIC ANALYSIS Superimposed gruel fractional test-meal curves of five cases of duodenal ulcer.



GASTRIC ANALYSIS Same patients as in Fig. 1, two days later, showing the striking neutralizing effect of sucking Nulacin tablets (3 an hour). Note the return of acidity when Nulacin is discontinued.

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On emerging from coma, gradual improvement occurred. Her condition assessed in June 1953, was as follows:

Her behaviour was irresponsible, showing an uninhibited interest in the male sex. She was restless and had difficulty in concentrating, being unable to apply herself to anything constructive. She was almost completely amnesic for her illness. Her prevailing mood was euphoric and there was no trace of her previous delusional ideas.

On physical examination involuntary alternating tremor of the right arm and hand were noted—there was also impairment of voluntary movement of this limb, particularly with regard to fine movements. The clinical picture suggested a mild organic dementia with involvement of the basal ganglia.

Her condition remained unchanged until her discharge on 17 June 1953. When seen a year later her physical condition was the same, but the irresponsible element in her behaviour had improved.

SUMMARY

A brief preliminary note on the condition post-hypoglycaemic coma is given, followed by 2 case reports.

The first case remained in coma for 80 hours and showed remarkable improvement in her mental condition. This was maintained for 4 months.

The second case remained in coma for 16 days. Thereafter her psychotic symptoms were relieved but she showed evidence of mild organic dementia and physical signs suggestive of damage to the basal ganglia.

OPSOMMING

Kort voorlopige aantekeninge oor die toestand van ná-hipoglykemie-koma word verstrekk, gevvolg deur verslae oor 2 gevalle.

Die eerste pasiënt was 80 uur lank bewusteloos, en haar geestestoestand het merkwaardig verbeter. Hierdie verbetering is 4 maande lank gehandhaaf.

Die tweede geval was dié van 'n pasiënt wat 16 dae lank bewusteloos gebly het. Daarna het daar 'n verligting van haar psigotiese simptome ingetree, maar sy het bewyse geopenbaar van ligte organiese demensie en fisiese tekenes wat die vermoede laat ontstaan het dat die basale senuknope beskadig was.

I wish to thank the Commissioner for Mental Hygiene, Dr. I. Vermooten, for permission to submit the first case for publication and Dr. H. Moross, Medical Superintendent, Tara Hospital, for permission in connexion with the second case. I also wish to thank Dr. R. Geerling, Head of the Department of Neurology and Psychiatry, Tara Hospital, for advice on the preparation of this paper, the contents of which were also discussed with the late Dr. M. Peskin, who was of great help to me with constructive criticism.

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THE CHANGING PATTERN OF DERMATOLOGY*

J. FROOTKO, M.D. (BERLIN)†
Johannesburg

The skin is the largest organ in the body. It amounts up to 15% of the total body weight. It is the anatomical boundary between the body and its environment, and is a shield without which life is impossible. It is a very complicated membrane containing a variety of glands, nerves, blood vessels and muscles. Its thickness, suppleness and attachments vary greatly in accordance with the special requirements of the various areas. Likewise, its ap-

pendages are varied in their distribution to the different areas concerned.

Its fundamental pathological changes are few and simple. Any cell or unit of the skin has but a triad of basic responses to the multiple factors causing disease. These basic responses are:

1. *Functional*—impairment of function without morphologic changes.
2. *Inflammatory*—degenerative changes following injury to the cell.
3. *Proliferative*—increase in the number of cells of a given type, namely tumours, benign or malignant.

* A paper read at a Clinical Meeting at Tara Hospital on 19 March 1958.

† Dermatologist.

Every cell type or system within the skin may show one of these stereotyped reaction patterns in response to an immense diversity of stresses. In most cases these various and unrelated stimuli can produce the same clinical picture, e.g. a dermatitis resulting from a contactant, such as nylon, can produce the same clinical picture as one resulting from an ingested drug such as a sulphonamide.

Like the nervous system, the skin is an ectodermal derivative and may be considered embryologically as a depressed portion of the central nervous system. If we consider the human organism as a functional whole, the skin becomes unique as an organ, in that it is not only the body's outermost physical boundary, but in many respects also the outermost boundary of the Ego.

When one asks a patient with a skin disability, 'What does your skin mean to you?' one often gets the reply, 'Well, it's what keeps me together. It is me. When it looks good I feel good. When it looks bad it gets me down, or I feel inferior'; and, of course, those suffering from severe acne often say, 'I want to get away from everything. It embarrasses me, and I have feelings of being dirty or inferior.'

The skin is also charged with emotional symbolism. This is clearly shown in phrases such as 'getting hot under the collar,' symbolizing rage; 'I am itching to get my hands on him' signifies a desire for an aggressive act. Phrases like 'My hair stood on end' and 'I am in a cold sweat' indicate intense anxiety, and being 'tough skinned' or 'thin skinned' denotes degrees of emotional sensitivity. The expression 'I would not want to be in his skin for anything' is the same as saying 'I don't want to be that person.' In this respect the skin can also be regarded as if it were the total personality.

As an instrument of expression it reflects intense emotional reaction in that it vividly exhibits physiological changes. Everybody understands that blushing signifies shame or embarrassment, that anger provokes flushing, that fear is expressed in blanching, and sweating (especially of the palms and soles) is a response to excessive emotional excitement. No doubt Nature provided prehistoric Man with these endowments for some definite purpose—probably associated with impending threat or emergency and so preparing the animal for some form of useful defence, either to fight or to run away. But since Man has become civilized, these advantages have disappeared. Society does not approve of these primitive instinctual drives and so blushing,

pallor and sweating have become a sort of atavistic skin language by which the inhibited instincts of the individual become betrayed.

Most people (and this includes doctors and nurses) have an irrational and often cruel attitude towards diseases of the skin. This attitude is quite out of proportion to the medical significance of most skin diseases—certainly to the most frequently encountered ones.

Why is this? If the skin can be regarded as the total personality, this attitude is understandable. For some people, especially women, minor blemishes can be so deeply traumatic that one wonders whether the concern is limited to cosmetic appearance or whether it is not rather a response to the fear that the spots on their skins may be spots on their characters and visible for all to see. One is constantly impressed by the patient asking 'Can this come on to my face?' It seems as if a skin lesion hidden by clothing is acceptable—but when exposed on face or hands it becomes difficult to accept. Just think of your own attitude to your own warts—the one on your face or hand, and the one on your trunk hidden by your clothes. It is impossible to escape the impression that the stigma attached to skin diseases may well arise from Man's desire to appear morally spotless and clean in the eyes of his fellow-men.

The study of the nature and causes of disease is progressing along the lines of integrated pathological thinking. In other words, we are now using morphological, functional, physical, chemical, bacteriological, experimental and clinical methods, as well as the recognition of the increasingly important role of economic and social conditions; so that to-day one seeks for the cause, prevention and cure of disease both in the individual and in his relationship to his fellow-men in his environment.

Nevertheless, the morphological, analytical and localistic concepts still persist, and in dermatology these concepts seem to be more deeply rooted than in any other of the medical disciplines.

The reason for this is that the skin's lesions are fully exposed to view, so that dermatology has been able to describe in detail, both at the macroscopic and microscopic anatomical levels, a great variety of skin conditions—some 700 have been described. Nevertheless, even detailed histological examinations have been unable to find characteristic changes warranting the nosological status of most of the conditions so examined.

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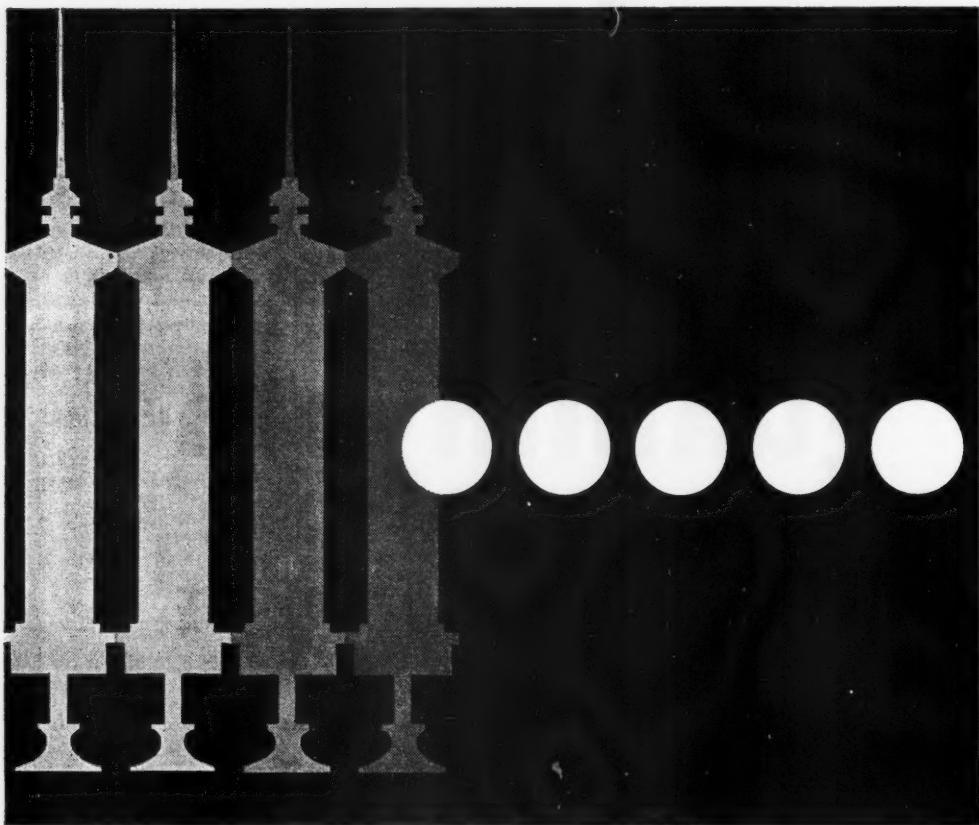
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To-day innumerable word pictures masquerade as diagnoses. Is it any wonder then that dermatology has achieved notoriety as the discipline that uses such long and incomprehensible words for conditions that seem to have no beginning and no end—a discipline that seems to have neither pathology nor therapy—a discipline, it seems, that spends most of its existence in differentiating various forms of a succession of identical pink spots to which it gives different names?

Skin diseases to-day account for about 5-7% of all cases seen in medical practitioners' offices in the country, and thus present a common and important problem in medical practice. Despite this, undergraduate teaching of dermatology is inexplicably neglected in the curricula of our medical schools. The inevitable result is that most doctors without postgraduate training in dermatology are seized by feelings of inferiority and consequently encounter disproportionate difficulties when called on to diagnose or manage even the simplest of skin conditions.

These feelings of inferiority, in terms of diagnostic and management skill, are possibly another reason why dermatology enjoys its present questionable status.

There are, no doubt, as many diseases of unknown causes affecting the brain, the heart, the liver, the bowel and other tissues and organs, as there are diseases of unknown cause affecting the skin. Nevertheless, the dermatologist is in the unenviable position of having to confess ignorance of the causes of conditions fully exposed for all to see. It is much easier to accept ignorance for causes of conditions deeply buried in a viscous. With the exception of infections, infestations, contact type skin reactions and neoplasms, most skin diseases are not only of unknown aetiology but are also of a chronic or recurrent nature. Thus specific treatment is sharply defined and limited, and one is continually faced by a persistent therapeutic frustration constantly driven home by every patient with a visible lesion or a persistent symptom that cannot and dare not be ignored or minimized.

Dermatological progress is intimately related to the progress of medicine, and the progress and evolution of medicine is connected more than in any other science with the essential needs of life itself. The historian Castiglioni¹ stated:

'It is perhaps not sufficiently appreciated that the modern art of healing is linked not only with magical rites and religious creeds, with primitive otopathy and classical Hippocratism, with dogmatic doctrines and revolutionary discoveries, but is also intimately associated with the economic, intellectual and politi-

cal conditions of the life of the different nations at different times, with their wealth and their miseries, with their trade, their laws, their wars, their philosophies, their literature and their arts.'

Thus in dermatology, as in any other expression of human endeavour and emotion, its present status can only be understood in the light of its historical significance.

The history of dermatology as a science dates to comparatively recent times, about to the time of Robert Willans' classification of skin diseases around the middle of the 18th century. This classification was based on the anatomical character of the lesions. At that time the industrial revolution in Britain was already well on its way, and the pattern of skin diseases had already become influenced by the rhythm of the machine.

Let us look back to the pattern of disease of the 17th century. The population of Europe was then about one tenth of its present size. The birth rate was high but the population increase was slow, for the mortality rate was extremely high. Less than half the children born survived to adulthood and life expectancy was about 19 years.

The disease pattern was still mediaeval. Plague, smallpox, dysentery and famine made life short and insecure; and parasitic infections, sepsis, infestations and the acute exanthemata were the chief causes of cutaneous disease. The century was a tempestuous one. It was dominated by the spirit of the Renaissance. The discovery of America had opened vast horizons to commerce, navigation and exploration, and the loss of Constantinople to the Turks drove westward the ideas, books and men well versed in ancient Greek traditions.

This was the century when the critical spirit of Man became autonomous and when he began to shake off the bonds of dogmatic scholasticism of mediaeval times. New ideas flourished, and political revolution against foreign domination was accompanied by a spiritual revolt against restraint of research in Science and Medicine. It was the century in which medical thought developed a decisive orientation towards the natural sciences and experimental research. In this period Descartes probed the problem of dualism and Galileo's researches in natural phenomena demonstrated that Nature's mysterious veil could be lifted. The physicians of the day began to realize that the secrets of life were most likely to be found in the field of the natural sciences. In spite of these developments the causes of disease were still largely unknown and it was only in the 18th century that the pattern of disease began to lose its mediaeval appearances.

The developments of the 18th century, in all their complex manifestations, were a logical evolution of this new political, social and scientific orientation. At the social level it ended with a great political reaction against dominant institutions, determined by a spirit of revolutionary idealism which culminated in the French and American revolutions, and this idealism found its spiritual origin in the decisive orientation of the thinkers of the previous century towards the natural and exact sciences.

At the economic level it produced the industrial revolution. The factory began to replace the home industries, and as the rhythm of the machine began to accelerate, the people flocked to the towns and cities. Dreadful working and living conditions produced slums, poverty and malnutrition and laid the foundations for ill health which we have not entirely erased to this day. Unsatisfactory social conditions resulted in ignorance, drunkenness and promiscuity and set the new pattern for disease. In the place of plague and smallpox came syphilis and tuberculosis as the great destroyers and the major causes of skin diseases. The rhythm of the machine began to succeed that of the human body and to this the increased pace of industrial development of the early 19th century added its own problems of malnutrition, deficiency diseases and physical and chemical causes of skin diseases. This disease pattern reflected the almost universal squalor, poverty, ignorance and indifference of the people, and set the pattern whereby Man's greatest hazard became Man himself.

Schleiden's recognition of the cellular nature of the living structure and Robert Brown's discovery of the cell nucleus together with Virchow's doctrine of cellular pathology laid the necessary foundations for modern medical thought, and by the end of the 19th century the discoveries of Pasteur and Robert Koch had revolutionized the whole concept of infectious diseases and paved the way for the enormous advances in the knowledge of the causes of innumerable conditions and, in particular, diseases caused by micro-organisms and parasites.

By 1875 in Britain, William Farr was able to report a permanent change in disease incidence. At last the intensive efforts of the reformers were beginning to bear fruit. The social circumstances of the people began to improve and the next 50 years witnessed a revolution in prevention, diagnosis and treatment. Skin diseases have shared fully in these changes.

It is still difficult to measure the effects of the advances made since the beginning of the century and particularly since the last world war. Taking the world as a whole, the most outstanding factors that have influenced the pattern of disease are probably the discovery of the chemotherapeutic and antibiotic agents, the control of diabetes and pernicious anaemia, improved nutrition (especially of expectant mothers) and the effects of DDT and the other insecticides, as well as the introduction of the steroid hormones and the modern advances in diagnostic, anaesthetic and surgical techniques. These advances have had a phenomenal influence on the pattern of disease and to-day, as far as dermatology is concerned, new factors are being looked for as causes of skin morbidity which, in spite of all advances, is increasing daily in incidence.

The first and most important factor is due to the genius of the chemist and the physicist. His discoveries, since the last war, have accentuated the economic and industrial expansion of most countries and an ever-increasing percentage of the population is being daily exposed to more and more chemical hazards, resulting in a high incidence of skin disease in industry; but here the causative factors are well known and industrial diseases of the skin can be well managed, at least at the organic level.

The second most important factor is the change in age distribution. Miss Hornby Smith² in 1952 showed in her report to the British Institute of Almoners that to-day there was one old aged pensioner to 6 of the working population and she estimated that this figure would be down to 1 in 4 by 1977. If I may put it this way, her figures show that in Britain 100 years ago there were 1 million people 65 years old and over—by 1977 there will be 8 million over this age.

As a result of this shift in age structure, Bachman *et al.*³ showed that whereas the death rate in 21 important diseases had declined, it had increased in the following 8 groups:

1. Heart diseases and cardiovascular diseases in general.
2. Cancer and other malignant tumours.
3. Diabetes.
4. Congenital malformations.
5. Duodenal and stomach ulceration.
6. Prostatic diseases.
7. Gall bladder calculi.
8. Exophthalmic goitre.

This trend of shift in age structure will be reflected in dermatology so that skin diseases of the later age groups will come increasingly under the notice of the practitioner.

Side by side with the increase in age of the population there is a decline of the birth rate.

The size of the family has fallen from 5 children in about 1900 to just under 2 children in 1950. In addition, the fact that both parents must often go out to work, is creating major social problems which must reflect, if not on the parents, certainly on the children, even at a dermatological level.

The pattern of disease has also been influenced by the enormous decline in acute and chronic infections, such as sepsis, osteomyelitis, bacterial endocarditis, pyaemias and septicaemias, syphilis and other venereal diseases, and tuberculosis. As far as dermatology is concerned, the latter two until recently played a major role in the incidence of skin diseases. It may well be said that the next 2 decades will relegate them to comparatively minor roles.

Dermatological thought must now attune itself to this rapidly changing background of the pattern of disease. In this connexion it is now possible to detach from the main structure the acute and chronic infections, the parasitic diseases, those due to vitamin deficiencies and those due primarily to physical and chemical causes.

Until now we have considered mainly the physical surroundings of Man's environment. The viruses, the pathogenic bacteria and the parasites do not, unfortunately, represent the whole story.

The trend now is to relate the causes of skin diseases in association with increasing age, and in particular with those skin conditions associated with increased nervous and emotional stress. The interplay of body and mind is reflected more clearly and quickly in the skin than in any other organ, so that early and efficient psychological investigation would pay a high dividend in the restriction of many disabling skin lesions. It seems to me that if the major efforts of the psychiatric service remains directed to the care of the psychotic and the senile, early and efficient care of others must suffer, and one would like to see the principle of preventive psychiatry extended, so that the many psychological problems of the infant, child, adult and the elderly could be more readily dealt with.

The most important factor in Man's environment is his fellow-man, and he has the unhappy knack of creating emotional and psychological difficulties for himself, which are of more far-reaching importance than those of the, let us say, sensitization reactions from contactants or drugs or bacteria. Because his life expectancy is now so much higher, he is now exposed to many more hazards than when death came early.

Bettley,⁴ in his skin practice, found that over 80% of cases fell into about 12 common conditions, whilst hundreds of uncommon, rare diseases made up the remainder of skin disorders. He showed that the incidence of various dermatoses among 18,000 new patients, seen at St. John's Hospital for skin diseases in London in 1951, included 36% belonging to the eczema-dermatitis group, and that the 12 most frequent diseases made up 78% of the total. It is this eczema-dermatitis group of patients that is preoccupying dermatological thought in regard to cause and treatment. It is felt that, apart from known organic factors, the major reason for the cause of these conditions is due to the difficulties arising from personal and environmental inter-relationships. To-day the sensitive patient may have his eczema aggravated by an anxiety about what a statesman several thousands of miles away may say the day after to-morrow.

Almost every individual is now subordinated to the requirements of society and the primitive emotions and instincts, by which our bodies are still governed, must be controlled, no matter what the price may be. Every one of us is well aware that the price is heavy, for the results are there for all to see. They show readily in those organs most closely associated with the mind, i.e. the cardiovascular system, the digestive tract and the skin.

In the final *Report of the Dermatology Committee of the Royal College of Physicians* (1947), the comment was made that the incidence of skin diseases in general practice was 6% of all cases and that in industry the loss of man-hours due to occupational skin disease exceeds that of any other form of industrial disease. Of these diseases, almost half belong to the eczema-dermatitis group, and the major reason for their cause may be associated with psychological factors. It is an obvious error to think of any somatic disease or reaction as purely exclusively somatic, or of any psychic disease as purely and exclusively psychic. The mind and the body together form a single unit, and are to be considered in a holistic sense. They are so integrated and so inextricably dovetailed and correlated that it is only in combination that they form the functioning whole. It is therefore no exaggeration to say that no psychic change can possibly fail to exert some effects on the body and on bodily functions, and that no bodily change can take place without some effect on the mind and the emotions.

The intelligent and critical study of the skin and its responses has always afforded a wonder-

ful opportunity for investigating just such delicate relationships and the intricate reciprocal effects between distant organs and systems. In the past the skin has played an important role in unravelling the fundamental mechanisms of carcinogenesis, immunological responses as well as the biological, physiological and pathological effects of heat, cold, light, Roentgen rays and other phenomena. This is because the skin is visible and all its parts are accessible, so that a clear-cut line can be established between cure and non-cure. For that reason skin investigation can take the lead in clarifying the reciprocating influences of mind and body and, in particular, as it affects dermatological disorders.

Although a considerable amount of work has been done in this field in recent years, the results are confusing and one feels that much of the literature presented as factual is still, in fact, speculative. Perhaps it is because the field of psychocutaneous disease is shared by many disciplines, such as general medicine and dermatology, psychiatry, psycho-analysis and general physiology and neurophysiology. The obscurities that exist may well be due to the traditional differences of approach by these disciplines to the presenting problems.

From a dermatological point of view I present to you 3 lists of conditions which include only those skin diseases and skin reactions, observed to respond promptly and unequivocally to the influences of the emotions and the psyche, as well as a list of some of the common skin diseases in which we have so far failed to prove indubitable and direct effects of psychic and emotional influences.

The first list is the physiological responses of the skin unequivocally proved to be elicited by psychic and emotional influences.⁵ They are:

1. Blushing (vasodilatation).
2. Pallor (vasoconstriction).
3. Sweating—which is secretion or out-flowing of sweat from the gland.
4. Goose pimples. This is a contraction of the arrectores pilorum.
5. Sensations of itching, tickling, pain, heat and cold.
6. The outpouring and the secretion of sebum.

The last has not been proved experimentally but occurs clinically in certain diseases of the central nervous system such as the facies oleosa of the parkinsonian syndrome.

The second list is that of the skin diseases and responses in which psychic and emotional influences have prompt major and undoubted direct effects.

They are:

1. Delusions of parasitosis; neurotic excoriations; trichotillomania; excoriations associated with acne;

skin artefacts; glossodynia (burning tongue); and cancero- and syphilophobia.

2. Intensification or reduction of itching and hence of scratching, and so of all the phenomena secondary to scratching and rubbing such as lichenification and secondary infection of the skin.

3. Changes in sweating: hyper-, hypo- and anhydrosis and dyshydrotic conditions and thus the skin changes, secondary or consequential to these alterations of sweating.

4. Cholinergic itching—dermographism and recurrent urticaria.

5. Herpes simplex. Although due to a virus, attacks are brought on by certain emotional effects; and finally

6. Warts of all kinds, sizes and shapes that seem to have been cured by suggestion.

The third list is the list of the most commonly encountered dermatoses in present-day practice. These are the disorders that are recurrent and fluctuating in their intensity, and where therapy gives rise to so much frustration, that I venture to say that the changing pattern in dermatological thought in regard to the causes of these conditions emanates from this therapeutic frustration. For it is here that the dermatologist at the end of a long day—a day filled with an inevitable succession of admissions of ignorance and repeated failures to relieve and to cure, is sorely tempted to answer the question, 'Is it my nerves doctor?' with 'Well, perhaps it is your nerves that gives you this trouble. Take a rest, go away for a rest—go away and let both of us have a rest.' It is this list of diseases where the psychic and emotional factors are as yet not proven to have prompt major and undoubted direct influences. It is in this list that we have the eczemas of all types, including the occupational eczemas, lichen planus, lichen chronicus simplex, urticaria, atopic dermatitis, dermatitis herpetiformis, psoriasis, the alopecias, the pigmentations and vitiligo, acne vulgaris and rosacea. This is the list that comprises the bread and butter of dermatological practice. In the search for new causes of these diseases one cannot help but feel that the nervous stress and emotional factors produced by our environment and personal inter-relationships play a major causative role. It is here that the dermatologist needs the help of the psychiatrist in unravelling causes and thus promoting more positive therapeutic approaches.

To sum up, it can be said without undue exaggeration that Man has succeeded so well in controlling his physical environment, that he must now start solving problems which only a few years ago did not exist. With a higher life expectancy, with increasing numbers, and the increasing complexity of living, he has to face mental and emotional stresses for which

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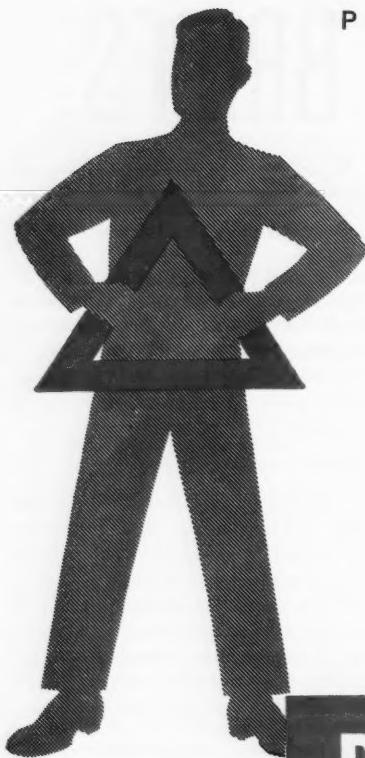
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there is no precedent in traditional wisdom, and in many instances nothing to replace the ancient spiritual values. The undernourished and disease-ridden member of some primitive community might, if he had the power, choose to retain his physical discomforts, rather than face the mental unrest of our highly civilized industrial community, where every disaster often exaggerated can be foreseen in advance of its coming. It seems that Man's main requirement for positive health to-day is, more than anything else, peace of mind. How that is to be achieved is indeed a problem, for it implies the reconciliation of his emotional and spiritual requirements, both at home and at work, with a vast impersonal machine of which he now forms an inseparable part.

If we can learn from history, I venture to say that the outlook is not too bleak. In all periods following major wars and great loss of human life, when social upheaval has shaken humanity, the people find themselves in a state of moral depression and in need of escape, and possibly also attuned to the expectation of miracles.

These symptoms are the sequelae of severe illness, and loss of equilibrium of the collective mind, just as the return to superstition and the access to all kinds of suggestion is characteristic of the individual who, having suffered from a grave disease, strives at the conscious and unconscious level towards regaining homeostasis.

From a historical point of view these symptoms are fortunately transitory and will disappear provided that the individual and the social structure are again able to resume normal function.

OPSOMMING

Dermatologie vorder langs die lyn van geïntegreerde patologiese denke.

Op die oomblik is dit moontlik om doeltreffende beheer uit te oefen oor velkwale veroorsaak deur akute en chroniese infeksies, deur veneriese siektes en tuberkulose, deur parasitiese siektes en infestasies, sowel as oor velkwale voortspruitende uit vitamiengebreke.

Dit het die dermatologiese patroon verander, en die moderne neiging is om die oorsake van talie velkwale, veral van die eksem-huidontstekingsgroep in assosiasie met aanwassende ouderdomsgroepe, in verband te bring met die spanning wat 'n uitbreidende nywerheidssamelewing op die onderlinge verhouding tussen mense uitoeft.

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THE PSYCHOLOGICAL ASPECT OF THE PATIENT

WHEN ADMITTED TO HOSPITAL*

A. L. BECKER, M.B., B.C.H.†
Tara Hospital, Johannesburg

In considering the psychological aspect of the patient when he is admitted to a hospital the stress should be on a personality involved, in more ways than one. The emphasis must be on the human being as a whole. This is not a minor point, though it may appear so. It is fundamental.

The personality should be regarded as a unique individual acting in and reacting to his environment—a person who has brought to the task a genetic inheritance which will not

only determine the scope of his potential but also define his limits. These potentialities have been and are being influenced by a host of factors, physical, biological, psychological and sociological. A person who is activated by the needs and drives for self-maintenance and self-realization, and in the face of an environment often stressful and often frustrating, has acquired certain adjustive techniques for the maintenance of his equilibrium. Genetic inheritance will predetermine certain factors, e.g. eye colour, hair colour, potential height and potential muscular development. The Intelligence Quotient and certain personality traits, e.g. of a schizophrenic or manic depressive diathesis, are others. Now a man may be

* Paper presented to the Post-Graduate Nursing Group at their Refresher Course for Medical and Surgical Nursing, on Wednesday, 6 July 1955, at Pretoria.

† Neuro-Psychiatric Registrar.

potentially 6 feet tall because of his genes, but because of his nurture he may never reach this. Yet he can never exceed 6 feet, no matter how rich his environment. Brought up in cramped surroundings, on a poor diet, prone to illness, put to work early (often work beyond his powers) this person may not reach his allotted 6 feet, and remain puny and undersized. His potential, however, remains unaltered. We have seen only too often a generation of tall strapping children born to undersized European immigrants.

To explain factors of adjustment and homeostasis, let us take the example of a schizoid personality with a high I.Q. There will be a drive for self realization in terms of his intelligence, but his schizoid personality will inhibit free, spontaneous social intercourse. Thus such a person may well tend towards a scientific research career. This would give him a fruitful outlet for his intellect yet the laboratory, giving a certain insulation, would limit the social contacts within bounds that he can handle.

The word 'patient' presupposes someone who is ill, under the care of a doctor or a nurse or in a hospital or institution. Should all that has gone before, then be ignored? Who is this person? What does he do? What is his background? What are his strivings? What anxieties and insecurities were present before this illness? It is only in the light of these that we can give him the greatest help in his illness. It is necessary to diagnose his disease as well as to understand what it means to him; how it affects him physically and personally; what threat there is to his future; how it affects his job; how it threatens his family at present and in the future; what factors he brings to the task of recovery and what will hinder improvement; how to enlist and augment the former and off-set the latter.

Another pertinent point is to distinguish between illness and disease. Illness is the disturbance of health that the patient recognizes. His symptoms prevent some of the natural activities of the body from being performed freely and efficiently, so that the usual requirements of living are met with pain or discomfort. Disease is an abnormal state of the body recognized by medical practitioners. The symptoms, the history, the physical examination and various investigations (physical and laboratory) indicate disturbances of bodily structure or functional activities. One person may be ill without having any demonstrable disease, while another may have a serious and even ultimately fatal disease without being ill.

There is a tendency in modern medicine to concentrate on the disease and to lose sight of the illness. The medical practitioner is mainly to blame for this. It is fairly easily understood in view of the tremendous advances in our knowledge of diseases and the remarkable technological skill that has been acquired in investigating them. But, unhappily, nurses are also being influenced to concentrate their attention more and more on the disease and to lose sight of the patient who is ill, whereas they could and should be enlisted to fill the breach and are actually in many ways better equipped to do so. The nurse spends much more time with the patient. The educational, social and economic status of most patients is more akin to that of the nurse. In the awe-inspiring atmosphere of the hospital, the patient is apt to regard the nurse as a person who has a good minor knowledge of the secrets and mysteries of medicine, but is not so thoroughly indoctrinated in its traditions and conventions that she would not take to him quite freely and give him her independent appraisal of the situation.

The following case makes the difference between disease and illness fairly clear and shows how important background and environment may be as a causative factor in illness and how it may influence effective treatment.

The patient was first seen in 1945 in hospital. The diagnosis on admission was mitral stenosis and incipient cardiac failure. Her main complaint was dyspnoea. She had a diastolic murmur and a very rapid pulse. She improved on bed rest without specific therapy and was soon discharged.

She was warded on 2 further occasions during the next 3 years. The disease was rheumatic heart disease—mitral stenosis, auricular fibrillation and incipient failure. On each occasion she improved on bed rest without specific therapy and was sent home.

She was next seen as a private patient. The diagnosis was as easy and as obvious as before, viz. mitral stenosis with incipient cardiac failure. But now there was much more. There was a home needing care. This included 3 children and an improvident, alcoholic husband. He only gave her a minimum for the bare necessities of life (which, of course, did not include the salary of a servant who might have done the heavy work of the household and kept her activities within a not unsatisfactory cardiac reserve), but abused and even assaulted her.

She was sent to the hospital and was discharged after 2 weeks—'recovered.' Four

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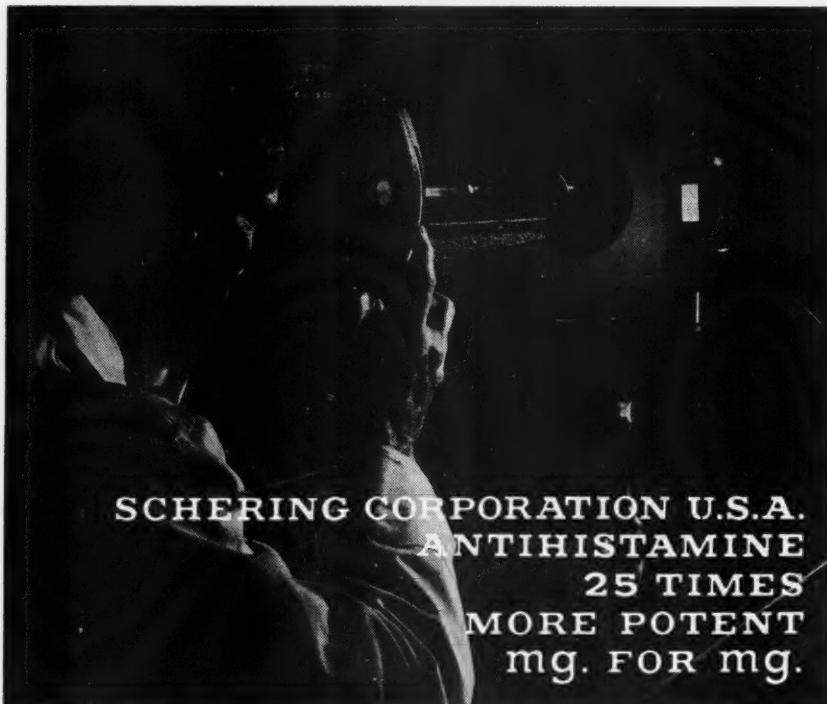
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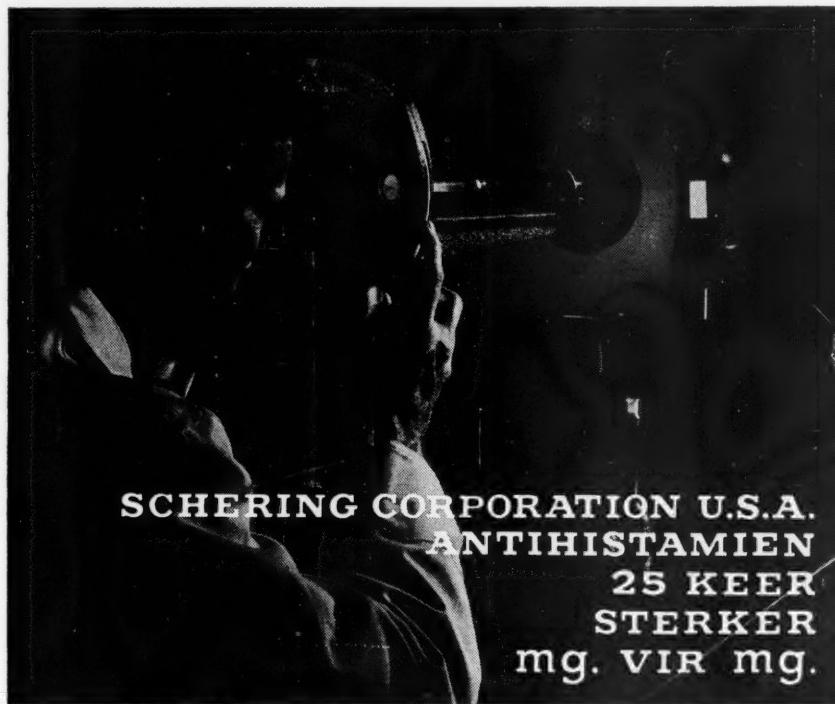
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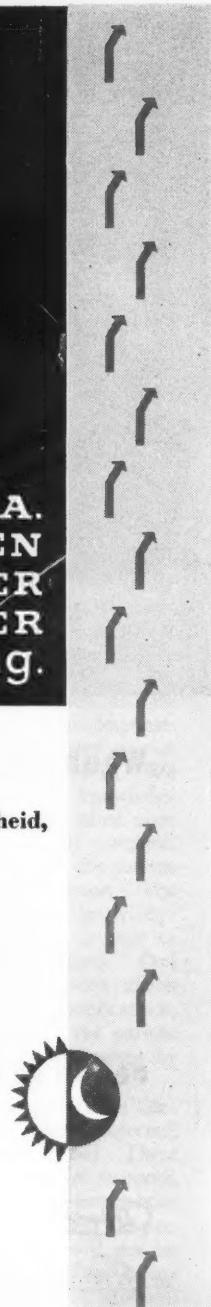
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years later, when last seen, she was still diseased, but no longer ill. In fact, she was in good health and this despite a pregnancy, terminating in an uneventful delivery. The therapeutic factors were a divorce and, later, a new husband (who supplied her needs in terms of kindness and affection) and, of course, a servant. Failure to visualize this patient as a dynamic individual within a dynamic environment obscured an all-important aspect of her illness.

This mobile interacting state of affairs does not cease on admission to a hospital. Any movement into an unknown region must precipitate anxiety. The patient finds himself in an entirely foreign environment and with a definite inability to cope with it. He is aware of a strange, cold, remote world about him. There are unfamiliar people, in uncommon costumes. They talk a language he used to know but with an admixture of foreign words. He moves in and out of weird rooms with weird furnishings. He is assailed by strange odours; and he 'needs must play his mournful scene alone.'

It is always important, in assessing the individual, to think in terms of his previous adjustment, cultural background and the seriousness of the illness, which must be viewed as to its actual gravity and how its gravity appears to the patient. The patient who is well adjusted with an easy social manner and who can make friends readily will settle down the sooner. He brings this facility for adjustment to the task and, because of his social skill, will sooner acquire a feeling of group-belonging and the security that goes with it. This patient rarely presents any problems beyond those of his disease—and is usually an excellent weapon for breaking down the isolation of the other patients. But we must be careful not to miss those 'who must put up a brave front,' who have a shame or a fear of showing their fear or by denying the reality of the situation, apparently contain their anxiety. These people, not unlike those who have previously made a more neurotic adjustment, will be the more anxious patients, in greater need of reassurance and yet less able to make personal or group contacts which will afford them this security.

The ethnic group and cultural background of the patient will have a profound influence on his reactions. His race, religion, social status and whether he is from an urban or a rural area, all bring in factors that will influence his original response to the illness and his subsequent reactions in hospital. There is an illuminating study from America which

high-lights certain cultural aspects. This investigation studied the reactions to pain of certain groups of patients. The group of 'Old American' patients complained comparatively little. The display of emotions was culturally taboo with them, and they were expected to bear their suffering with a 'stiff upper lip.' However, another group made up of Jews and Italians had much more emotional responses. There was no cultural inhibition about showing their feelings. But further features came to light which explained much of their subsequent behaviour. Though both groups reacted in a similar, highly emotional manner, there were significant differences in attitude. The Italian was mostly concerned with the immediate problem. He was suffering from pain and craved relief. Once treated for this he would normally settle down. The Jew, however, though discomforted by the pain, was concerned mainly about how this illness would affect his future welfare and through him the welfare of his family. This often led to a reluctance to have any drug in case it affected adversely the eventual outcome of the disease—all in all a sceptical, suspicious patient.

A serious or grave illness, especially if the patient knows about it, is more likely to create grave anxiety and apprehension in any patient irrespective of his premorbid personality. But it is always the view that the patient will take of his illness that must be appreciated, because this is going to be the criterion of his response. We must try not to sit in judgment on his attitude; we must try to understand it. We are too prone to project our own knowledge and experience on to the patient. Most cases of acute appendicitis have a happy outcome, but this does not minimize the pain the patient feels, or his anxiety and apprehension. The confidence that comes from the knowledge that the prognosis is encouraging is part of our armamentarium not the patient's. One may give an average of 30 electro-convulsion treatments a week without any complications, but this is not the experience of the patient who is going to be rendered unconscious by the treatment.

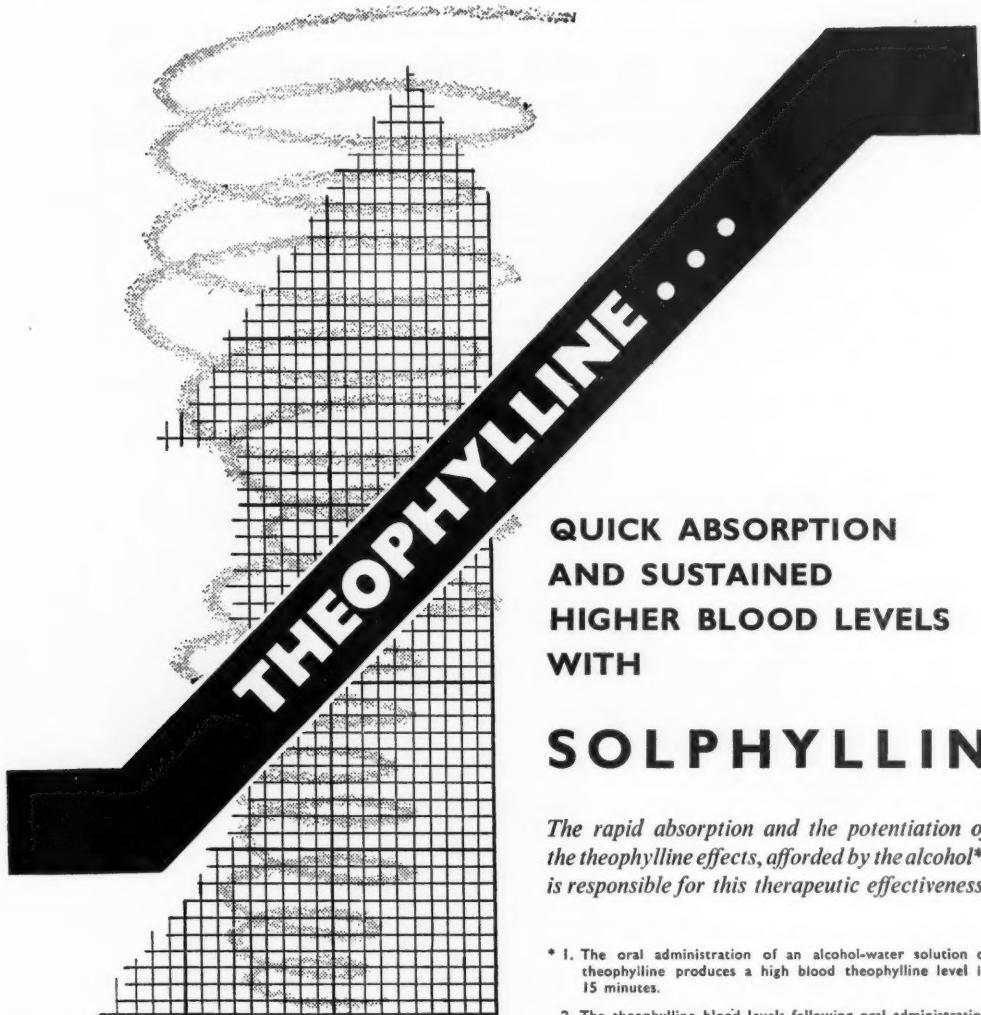
Other aspects of the disease should be considered. How much was the illness expected, and what is the outcome likely to be? These factors lead to certain variations in response. Most pregnant women expect to go into labour when they come to term. Most of them are prepared to accept that the delivery will not be painless. Most of them hope for the happy outcome of a live, healthy baby. All this will produce behaviour dependent on the factors

already mentioned. But let that labour commence at 28 weeks. She did not expect her pains at this time and she will not be as ready for them. Her acceptance of the pain will be even more reduced because the outcome may no longer loom as fulfilment but as bitter disappointment. On the other hand, if she is unmarried, the outcome now may be a release from an untenable situation and may result in a greater acceptancy on her part. All satisfied patients are alike; every dissatisfied patient is unhappy in his own way. It is the duty of the medical staff to create the bridges from the one to the other. Under stress the patient may try to get relief from his anxiety by insulating himself or being negativistic. Regression to more aggressive or attention-seeking forms of behaviour may be the preferred technique. But if we find the patient difficult to manage we must remember that the patient is finding us just as difficult or even worse, and is, in addition, less well equipped for the task. Antagonistic behaviour need not continue indefinitely. With the release from emotional tension that will come from recognition, understanding and reassurance, the patient's activity can be directed to more constructive use. There will be a move away from morbid thoughts and egocentrism. The bridges are the creation of interpersonal relationships between patient and doctor, patient and nurse and patient and patient. As we have said, the nurse is in an ideal position to fulfil this function. She is socially more acceptable for the reasons mentioned. She spends more time with him. She will be the one to accompany him about the hospital, to the X-ray department, to the theatre, 'his refuge and strength and ever-present help in trouble.' But this would be done with greater ease when the lead is given by the practitioner. The desired therapeutic atmosphere can be engendered by him, not necessarily in his handling of the patient but even in his relationship with the nursing staff.

Now this human aspect is being lost sight of in many hospitals. This is a modern trend, where technological advances have outstripped the social skills and it is seen fairly generally in Western civilizations. The last half century has seen an almost unbelievable advance in technical skills and with it a breakdown of the old social system. Social barriers can be breached with such ease they do not seem to exist. The labourer's son may become a judge; the bootmaker's daughter, a doctor; and a farmboy, a Premier. The large family units have become small isolated groups and

even this unit is undefined. The mother is often part-time mother, part-time typist. Father is often not master of the home but his wife's equal partner. Formerly our roots were fixed, our place in society fairly clear, and the environment reasonably familiar and manageable. We knew what to expect and what was expected of us. Now we have been uprooted. Our horizons are infinite. We meet people from every walk of life and from every corner of the earth. New people, new things, new ideas are forced on us, through the speed and facility of transport, and through our newspapers, cinemas, wireless and television. But many of us were trained in the rigidity that was satisfactory in the Victorian era and lack the plasticity required for present-day adjustment. Thus people have become more isolated and less able to make and maintain human contacts and handle their social relationships. This has occurred in circumstances when there is even greater need in the individual for the feeling of group-belonging and group-security to offset the anxieties of his time.

But to-day even industry is re-discovering the 'individual' and it is time that in our hospitals we re-discover what we should never have lost in the first instance, *the importance of the individual as a personality*. This recognition cannot be atomistic and refer to the patient alone, but must include the acceptance of every member of the hospital staff. Anxiety precipitates anxiety, and any unresolved or maldirected interpersonal tensions or inter-departmental tensions must reflect on the members of the staff and so on the patients. Our objective must be to so gear the hospital that it may cater for the needs of the individual personality, staff and patient alike. Perhaps then we would not separate the newly born infant from its mother. The dichotomy of mother and child is unnatural and we must learn to recognize the interdependent unit of mother and infant and their reciprocal needs. We would not attempt to create an automaton of that infant; to feed by the clock, to sleep by the clock, perhaps to be loved by the clock. Later, if that child is admitted to hospital, we would not fail to minimize the separation from its mother; not think of an independent unit, nor a dependent unit, but again an interdependent one. Perhaps we might reduce the cold, inhuman, austere efficiency of the hospital that runs on smooth wheels to a set schedule. Efficiency is not to be decried. It is the inhumanness that one criticizes. There is need of warmth and recognition of the uniqueness of the individual. To



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stress again the feature of interdependence let us remember that as much as the patient needs us, so much do we need the patient, each in his own way.

A brief mention has been made of the patient's milieu and how it may affect him and his reactions. But what of the reaction of his family, friends and associates to his illness? One thing is certain, if one has failed to allay the anxiety of the patient one is not likely to succeed in diminishing the anxiety of the relatives. In fact, tension will be mounting on all sides. A worried patient is going to be rendered distraught by over-anxious visitors. Worried relatives are going to be rendered distraught by the over-anxious patient. And a harassed and over-worked staff is going to be rendered distraught by both. Yet if we handle all these people as they need and deserve to be, we would be enlisting some of our stoutest allies instead of nullifying their effectiveness and increasing and adding to the burdens of the patients and their attendants.

At present, there are persistent complaints about the passing of the general practitioner from the hospital scene and of the family doctor generally. This is no doubt to a large extent due to the technological progress and social chaos of our time. These wise men knew all that we have tried to say because they were not afraid to meet and know their patients, as well as the nurses and the hospital staff.

We should re-introduce their understanding, appreciation and acceptance of those for whom and with whom we work—for the benefit of our patients, the happiness of the medical aids and our own pleasure and satisfaction.

OPSOMMING

Die belangrikheid daarvan om die pasiënt uit 'n holistiese oogpunt te betrag, word beklemtoon, en die persoonlikheid van 'n 'unieke individu' word beskryf.

Siektes en kwale word gedifferensieer, en hul belangrikheid vir die pasiënt word bespreek.

Die effek van die aanpassings-, etniese en kulturele bestanddele van die persoonlikheid op gedrag in die hospitaal word aangestip.

Tegnologiese vorderings, die verlies van sosiale bekwaamhede en die isolasie van die individu word beskryf, en 'n pleidooi word gelewer vir die herontdekking en erkenning van die unieke individuele persoonlikheid en sy behoeftes, en die afhanklikheid en onderlinge afhanklikheid van menslike wesens—pasiënte en ander.

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TESTAMENTARY CAPACITY

R. GEERLING, ARTS (HOLLAND), M.D. (AMSTERDAM)*
Tara Hospital, Johannesburg

In law testamentary capacity relates to a triad of capacities, viz.:

1. Active capacity—the capacity to make a will.
2. Passive capacity—the capacity to benefit under a will.
3. Capacity to witness a will.

The following discussion will be concerned with the first of these only.

To determine what active capacity entails, the question arises as to what is a will or testament? A will or testament is a document drawn by or for a person named the testator, by which he disposes of his property to others, but where such disposal takes effect only after the testator's death. This intended future dis-

posal is a unilateral act and is thus not a contract. The effect of this is that a will is revocable at any time before the testator's death. After any such revocation he can again draw a new will whenever he pleases. Also, by drawing a second or third will, the previous wills are revoked.

To draw a will, therefore, the testator must take into account the nature and extent of his property in order to know what and how to distribute it and, furthermore, the persons related to him and others whom he would wish to receive benefits from him.

These factors entail, medically speaking, the presence of memory of events and persons and of a proper judgment of the testator. If he is possessed of all these he is said in law to have a 'sound disposing mind'.

* Chief Neuro-Psychiatrist.

The test of testamentary capacity is stated in *Boughton v. Knight*¹ as follows:

'The question of testamentary capacity is eminently a practical one in which the good sense of men of the world is called into action and it is one which does not depend solely on scientific or legal definition.'

Though this may be perfectly correct and true it is not so helpful as the classic test of testamentary power laid down in *Banks v. Goodfellow*² where Cockburn, C.J., said:

'It is essential to the exercise of such a power that a testator shall understand the nature of the act and its effects; shall understand the extent of the property of which he is disposing; shall be able to comprehend and appreciate the claims to which he ought to give effect; and, with a view to the latter object, that no disorder of the mind shall poison his affections, pervert his sense of right; or prevent the exercise of his natural faculties—that no insane delusion shall influence his will in disposing of his property and bring about a disposal of it which, if the mind had been sound, would not have been made. . . .'

The purpose is thus, not only to determine to whom the testator wishes to leave his property, but also whether he wishes to exclude certain persons from such benefit, as was indicated in the case of *Harwood v. Barker*³ where Erskine, J., said:

'but he must also have capacity to comprehend the extent of his property and the *nature and claims of others whom by his will be is excluding from all participation in that property*; and the protection of the law is in no cases more needed than it is in those where the mind has been too much enfeebled to comprehend more objects than one, and most specially when that one object may be so fixed in the attention of the invalid as to shut out all others that might require consideration.'

The testamentary disposal of property is thus determined by the will of the testator, such will being determined by:

- i. The testator's knowledge of the extent of his property, and
- ii. The testator's knowledge of those persons related and not related to him, who could or are entitled to make claim on his bounty.

The knowledge of all these facts entails the presence of 'memory' in the testator. It follows, therefore, that if such memory for the extent of his possessions and for his relations to others is absent, that complete incapacity exists. But it should be noted that with 'memory for the extent of his possessions' is meant not a faultless memory, but an 'approximate knowledge' of such possessions. Furthermore, in relation to the knowledge of those who could make a claim on him, such knowledge need not be faultless either.

The testator might know, for instance, such persons still by their first names only, or not remember such names at all but only his relationship to such persons, for instance, cousin, nephew, grandchild, etc. yet such knowledge may be sufficient for testamentary capacity.

This is stated in *Banks v. Goodfellow (supra)* by Cockburn, C.J., as follows:

'By the terms "a sound and disposing mind and memory" it has not been understood that a testator must possess those qualities of the mind in the highest degree; otherwise very few could make testaments at all; neither has it been understood that he must possess them in as great a degree as he may have formerly done; for even this would disable most men in the decline of life; the mind may have been in some degree enfeebled; and yet there may be enough left clearly to discern and discreetly to judge of all those things, and all those circumstances, which enter into the nature of a rational, fair, and just testament.'⁴

These facts bring us to a further basic principle of testamentary capacity, namely, *the type of testament*. A will may be anything from a very complicated document to a very simple one. When testamentary capacity has to be determined, such determination rests upon the comparison between the contents of that document and the testator's condition physically and mentally. It could be, for instance, that a testator could make or has made a simple will, but where it was quite impossible for him to have drawn a very complicated one, even with the assistance of others, or where, if drawn by another, it would have been quite impossible for him to have understood or grasped the contents of such a complicated will, even if read over to him slowly clause by clause. *The conclusion is thus that it is not a question whether a testator can make or could have made 'a' will, but whether a particular testator can make or could have made a particular will at a particular time.*

The next point to consider is that of a 'free will'. The disposal, by the testator, of his assets after his death should be determined by a 'free will' uninfluenced by any external or internal adverse factors, which might affect the exercise of such free will adversely. This was expressed by Roper, J., in *Lewin v. Lewin*⁴ in the following terms:

'It is abundantly clear from the authorities that it is not sufficient that the testator understood and intended the dispositions which he was making in his will; *it is necessary further that he shall have been able to comprehend and appreciate the claims of his various relatives upon his bounty, without any poisoning of his affections or perversion of his sense of right, due to mental disorder*'.

If thus the will of the testator is being influenced by delusions⁵ or hallucinations, and such delusions and hallucinations pertain to those who could have a claim on the testator's bounty, that influence on the will could have the effect of invalidating the testament. It is, however, a requirement that such delusion or hallucination must have or have had a direct influence upon the performance of such parti-

cular act, in this case thus of drawing a will. This was laid down in the case of Rehne's Estate v. Rehne⁵ where de Villiers, J.P., said:

'All legal acts done by such person during such period are presumed to be void, but such presumption will be rebutted if it is made to appear to the court that such insane delusion did not and was not calculated to influence such person in doing such act. If such presumption is not rebutted the act will be declared void; if it is rebutted the act will be valid. The act is not valid by reason merely that the person, while having such insane delusion, understood the nature of the act and intended to do it.'

A further factor to be taken into consideration during the act of will-making by the testator is the absence or presence of defects of speech. In considering speech defects which could influence the making of a will, the type of speech defect should be considered.

(a) *Dysarthria or Anarthria*:^{6,7} This type of speech defect is one which is due to partial or total paralysis of the muscles of speech involving tongue, palate and face. The dysarthria (indistinct speech) usually gradually progresses to anarthria (inability to speak). In cases of this type the person so affected cannot express himself to others by means of speech. But, if the extremities are unaffected or only partially, the person can still express himself by means of the written word, since the symbols of speech and writing have remained unaffected. This means of communication should therefore be utilized in determining the testator's wishes. If the extremities are also paralysed then the process of determination of the person's wishes is more laborious, since questions put should be replied to by the interrogator himself and watching for signs and gestures of assent or dissent, and watching the mimicry of the person interrogated. By this means eventually the wishes of the testator may be determined.

(b) *The Aphasias*: The aphasias for practical purposes are divided into:

1. Motor aphasia.
2. Sensory aphasia.
3. Mixed sensory-motor aphasia.

The motor aphasia is the expressive speech defect and the sensory aphasia is the receptive speech defect. Both these types are subdivided into the subcortical, transcortical and cortical types. For the purposes of this discussion, however, it is not possible to go into the detailed symptomatology of each of these separately. Sufficient to say, then, that the disturbances of the cortical lesions, both motor and sensory, are the most severe ones, and may be associated with agraphia (inability to write) and alexia (inability to read). It is further generally accepted that, in those cases where the cortical aphasia develops, there is a de-

velopment at the same time of intellect disturbances, and consequently also of a defective judgment.

In the first instance, therefore, the patient cannot express himself by word of mouth or by the symbols of writing, though he can understand what is being said to him. In these instances the interrogator is dependent on carefully watching and interpreting the mimetic movements and gestures of assent or dissent of the patient.

In the second type the patient does not understand either the spoken or written word and it is not possible, therefore, for anybody to communicate with him. Furthermore, it is noted that intellect defects in these cases always seem to be far more pronounced than in the cases of motor aphasia. To all intents and purposes the contact of the patient with the outside world is completely cut off. In the case of sensory aphasia the difficulties are thus enormously increased and it may be said that testamentary capacity, if still present, is one in which only the simplest will can be made. Mostly, however, such capacity will be non-existent.

If a mental disorder is associated with an aphasia it is evident that the examination for testamentary capacity is one fraught with difficulties and pitfalls. Such examination will entail several sessions, as the factor of quick fatigue will have to be avoided.

In the case of the making of a will by a person suffering from an aphasia it is advisable that during the examinations both the medical practitioner and the lawyer of the testator be present. The testament should be altered time and again and be read over to the testator to test his assent or dissent to the different clauses, until all clauses are eventually repeatedly agreed to. If the testament is disputed, the court will have the benefit of the opinion of both the medical practitioner and the legal adviser of the testator. The final decision then always lies with the court.

Variations in Symptomatology: In all cases for determination of testamentary capacity, i.e. those cases of mental disorder with or without associated aphasias, it is of paramount importance to discover and take into account the underlying causal factor of the disease. This is especially necessary to determine firstly whether the condition may give rise to variations in intensity of the symptoms and, secondly, whether due to such variations lucid intervals may occur during which testamentary capacity might be present, even if temporarily. From the foregoing it is thus clear that a

person, though he may be mentally disordered, and even certified as such under the Mental Disorders Act of 1916, he may still have testamentary capacity. Furthermore, with respect to supervening physical infirmity or decay of advancing age the dictum of Cockburn, C.J., in *Banks v. Goodfellow*² (*supra*) clarifies the position by his statement:

'It may be here not unimportant to advert to the law relating to unsoundness of mind arising from another cause, namely from want of intelligence occasioned by defective organisation, or by supervening physical infirmity or by decay of advancing age, as distinguished from mental derangement, such defect of intelligence being equally a cause of incapacity. In these cases it is admitted on all hands that though the mental power may be reduced below the ordinary standard, yet if there be sufficient intelligence to understand and appreciate the testamentary act in its different bearings the power to make a will remains'.

In conclusion, therefore, it may be stated that the medical practitioner who is required to express an opinion as to the testamentary capacity of a person, should verify the following facts:

1. That the testator has knowledge of the nature of the act he is undertaking.
2. That he has knowledge of the effect of the will.
3. That he has knowledge of the nature and extent of his property *within reasonable limits*.
4. That he has a clear appreciation of which relatives, and others, have a reasonable claim on his bounty, and of those whom he would wish to exclude from his will.
5. Whether there are any insane delusions present and, if so, whether such insane delusions have any influence on the act itself to be performed or on the volition of the testator, and in which way such influence is acting.
6. Whether there is any disorder of judgment or whether there are any other disorders of the mind which might influence the testator's decisions concerning the disposal of his property.
7. Whether by reason of mental disorder, senile psychosis or feeble-mindedness, the testator may be unduly suggestible and therefore easily influenced by others, and as a result

the will might prove to be an improper one.

Once these facts have been verified the medical practitioner can formulate his opinion about the testamentary capacity of the testator, as long as he keeps in mind the requirements laid down by the court in respect of each of the facts enumerated. In difficult cases or in cases of doubt it is always advisable to consult the testator's lawyer.

One last point should be brought up as a warning. If the medical practitioner is asked to witness a will he should enquire why he has been asked to do so. If necessary he should have the will read over to him before signing the document as a witness in order to judge whether the particular testator was able to understand that particular will. If this request be refused, and he does sign such a will as a witness, he should add in writing above his signature a sentence to the effect that he has solely witnessed the testator's signature and not the will.

OPSUMMING

Vir die doeleindes van praktiese gebruik deur mediese praktyks word die betekenis van en die vereistes vir 'n geldige testament uiteengesit.

Die effek van geestelike versteurings en fisiese swakheid, asook van disartrie en anamtrie en die verskillende vorms van afasie op die vermoë om 'n testament te maak, word bespreek in die lig van hofuitsprake.

Hierdie besprekking loop uit op 'n uiteensetting van punte wat deur 'n mediese praktyk geverifieer moet word voordat hy 'n mening oor die testamentêre bevoegdheid van 'n persoon uitspreek.

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NOTES AND NEWS : BERIGTE

Prof. T. Gillman, Head of the Department of Physiology, Durban Medical School, has left on a 6-month overseas visit on sabbatical leave. He has been awarded a Royal Society and Nuffield Foundation Commonwealth Bursary, during the tenure of which he will work in London with Prof. P. B. Medawar, F.R.S., on *Tissue Immunology in Relation to Carcinoma, Tissue Grafting and Tissue Repair*.

He has also received a Rockefeller Award which will enable him to visit the U.S.A. for a 2-month period to study *Recent Advances in Medical Education*.

Professor Gillman's Unit in Durban has received from the Nuffield Foundation a donation of £3,000 for research (during 1959) into the problems of ageing.



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A MORE POTENT DERIVATIVE OF CHLORTRIIDE

Merck Sharp & Dohme announce the development of a more potent derivative of Chlortriide (chlorothiazide) in the form of Dichlotriide (hydrochlorothiazide).

Preliminary clinical reports indicate that this more active product may be a valuable therapeutic addition to the diuretic drugs used in the treatment of oedema, toxæmia of pregnancy, hypertension, etc.

Mr. M. A. Lautré, F.R.C.S. (Eng.), has changed his address to the Florence Nightingale Nursing Home, 6th Floor, Kotze Street, Hillbrow, Johannesburg. (Telephone: 44-3801).

Dr. Carl Barrett, M.B., Ch.B. (Leeds), M.R.C.O.G., D.O.B.S., R.C.O.G., has commenced practice as a Specialist Obstetrician and Gynaecologist at 26-28 Jenner Chambers, Jeppe Street, Johannesburg. (Telephones: — Rooms: 22-4464; Residence: 46-4968).

INTERNATIONAL CONGRESS OF GASTROENTEROLOGY
LEIDEN (THE NETHERLANDS), 20 TO 24 APRIL 1960

The Sixth Meeting of the Association of the National European and Mediterranean Societies of Gastroenterology, organized by the Association of Dutch Gastroenterologists, will be held in Leiden, the Netherlands, from 20 to 24 April 1960.

The main themes of the conference will be:

1. Pathology of the Small Intestine;

2. Hepatitis, Cirrhosis Hepatis and their Possible Connexion.

Panel discussions, lectures and film shows will be arranged in connexion with these themes and related subjects. Scientific and technical-commercial exhibits will be also organized.

Original reports on these subjects or any other gastroenterological subject, either clinical or in the field of the basic sciences, are invited for submission and will be accepted for panel discussion or publication if approved by the Scientific Program Committee.

Titles for papers together with a summary of not more than 200 words should be sent not later than 1 August 1959, to Dr. B. K. Boom, Congress Office, Department of Gastroenterology, University Hospital, Leiden, the Netherlands.

Official Language: English.

Working Languages: English, French, German, Spanish (with simultaneous translation).

Registration Fee (including an official reception, a banquet and an excursion): Full member: U.S. \$45. Accompanying family members: U.S. \$20.

After 1 November 1959, the registration fee for full members will be U.S. \$55. The fees quoted in U.S. dollars can be paid also in Dutch guilders or any other transferable currency.

For further information and registration apply to the Congress Office of the Sixth Meeting of the Association of the National European and Mediterranean Societies of Gastroenterology, Department of Gastroenterology, University Hospital, Leiden, the Netherlands, or to the Secretary of the National Societies of Gastroenterologists.

PREPARATE EN TOESTELLE

TACE

DIE UNIEKE, MONDELINGE, IN LIGGAAMSVET OPGEBERGDE ESTROGEEN

Samestelling en Efffek: Tace is 'n sintetiese verbinding met 'n kragtige estrogenefek. Iedere kapsule bevat 12 mg. Tace, 'n soort chlorotrianiseen (tri-para-anisielchloro-ctileen) in koringolie.

Omdat die formule van Tace heeltemal anders is, besit dit 'n aantal unieke eienskappe:

Volgende op mondelinge toediening word dit vinnig geabsorbeer, en hoop dan gedeeltelik in die liggaamsvet op. Hieruit word dit geleidelik in steeds afnemende hoeveelhede oor 'n aansienlike tydperk vrygestel.

By diere kom vergroting van die harsingslymklier wat 'n kenmerk van die herhaalde toediening van ander estrogene is, nie voor nie. Insgelyk is daar klinies bewys dat Tace geen bewybare effek op die bynier het nie, en, in teenstelling met die ander estrogene, ook nie hipertrofie of hiperaktiwiteit van die bynier veroorsaak nie.

Voordele: Vir die klimakteriumsindroom—in gevalle waar die maandstonde opgebou het maar die simptome voortduur. Omdat Tace in die liggaamsvet opgeberg word, verseker dit 'n egalige, ononderbroke vrystelling van estrogen wat voortduur selfs nadat terapie gestaak is. Die vinnige, simptomatiese verligting word derhalwe verleng, en kan dikwels maande lank voortduur nadat Tace ontrek is. Dit is klinies bewys deur volgehoue skede-verhoorning en verminderde harsingslymklier-gonadotrofie-peile.

Geleidelike estrogenvrystelling uit die liggaamsvet stimuleer die afskeiding van natuurlike hormone,

en help die pasiënt om haar fisiologiese by die normale, simptoomvrye na-volwasse stadium aan te pas.

Tace gee die pasiënt weer eens die gevoel dat sy 'noodig' is, en die egalig verminderende estrogenpeile verban die hoogte- en laagtepunt-effek van estrogene met 'n kortstondige effek. Ten gevolge hiervan word onttrekkingsbloeding feitlik geheel en al uitgeskakel. By pasiënte wie se simptome voortduur nadat die maandstonde opgehou het, kan een kort behandeling met Tace—2 kapsules per dag gedurende 'n tydperk van 30 dae—dikwels na-menopause-aanpassing bespoedig en die pasiënt onafhanklik van langdurige estrogenterapie maak. In ernstige en wederkerende gevalle kan addisionele behandellings met Tace af en toe nodig wees.

Oorvulling van die Borste na Bevalling: Kliniste rapporteer dat Tace 'n voortreflike estrogen vir die onderdrukking van melkafseidings is. Die feit dat dit in die liggaamsvet opgeberg en geleidelik vrygestel word nadat terapie gestaak is, voorkom in 'n aansienlike mate dat die borste opnuut oorvul raak, en skakel onttrekkingsbloeding feitlik heeltemal uit.

Prostaatkarsinoom: Tace het werklik bevredigende en selfs dramatiese gevolge gehad tydens die ver-



liggende behandeling van prostaatkarsinoom. *Tace* se doeltreffende resultate blyk uit die verlenging van pyn, die toename in gewig, en die verbetering van die patologiese en bloedbeelde wat op die gebruik daarvan gevvolg het. In baie gevalle is hierdie heilsame effekte tot stand gebring by pasiënte wat sonder welslae met ander estrogene behandel is.

Omdat *Tace*, in teenstelling met ander estrogene, geen bewysbare uitwerking op die harsingslymklier en die byniet het nie, word die gevraar van 'n androgeen terugslag vermy. Die voortreflike uitwerking van *Tace*, in vergelyking met ander estrogene, en die hoe oorlewingssyfers by pasiënte wat met *Tace* behandel word, moet miskien toeskryf word aan die feit dat hierdie middel nie die byniet aktiever nie. Afgesien van die feit dat *Tace* langdurige beskerming gedurende vier-en-twintig uur van elke dag verleen, word dit ook besonder goed verdra. Ginekomastie, mislikheid en braking word selde teëgekom.

Indikasies en Dosis: Verligting van die meno-pause-symptome: 2-*Tace*-kapsules per dag gedurende 'n tydperk van 30 dae. In ernstige gevalle waar die symptome terugkeer, sal addisionele behandelings miskien nodig wees.

Orvulling van die Borste na Bevralling: 4 *Tace*-kapsules per dag gedurende 'n tydperk van 7 dae. Vir verligtende behandeling van prostaatkarsinoom: 1 of 2 *Tace*-kapsules per dag.

Let Wel: Geleidelike vrystelling uit die vetyldepôts maak *Tace* 'n besonder waardevolle middel vir die behandeling van die klimakteriumpasient wie se maandstone verdwyn het. Die betreklike vryheid van ontrekkingsbloeding by pasiënte wat met *Tace* behandel word, beteken dat dit nie gebruik kan word in gevalle waar estrogene nodig is om siklusbloeding tweeweeg te bring nie.

Besikbaarstelling: Bottels van 60 en 300. Iedere kapsule bevat 12 mg. *Tace* (chlorotrianiseen).

Vervaardig: Onder beheer van die Wm. S. Merrell Company, Cincinnati, V.S.A.

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MERBENTYL

'N SELEKTIEWE KRAMPWERENDE MIDDEL MET 'N DUBBELE UITWERKING

Samestelling en Effek: *Merbentyl* is die Merrell-handelsnaam vir disiklomienhidrochloried (di-etiel-aminokarboktabisikloheksiel).

Merbentyl is 'n nie-narkotiese sintetiese verbinding wat 'n kragtige, dubbele spasmolitiese effek op die gladde spier van die maagdermankaal uitoefen. Studies het aangetoon dat dit 'n lae toksisiteit en geen kumulatiewe uitwerking het nie.

Muskulotropiese Effek: *Merbentyl* stem in die opsig met papawerien ooreen dat dit die kramp verlig deur die regstreekse verslapping van die gladde spier. Dit is egter nie-narkoties omdat dit nie aan die opioidalkaloide verwant is nie.

Neurotropiese Effek: Die uitwerking van asetiel-cholien by die agter-senuweeknoop-parasimpatisiese senuwee-eindpunte word selektief deur *Merbentyl* versper. Hierdie anticholinergiese effek bly beperk tot die gladde spier van die maagdermankaal. Die senuweebane wat onder organe innerveer, word hoegegaan nie geaffekteer nie.

Merbentyl het feitlik geen effek op maagskeiding nie.

Voordele: Omdat *Merbentyl* 'n selektieve, dubbele spasmolitiese effek het, skakel dit onwenslike newe-effekte byna geheel en al uit. Laboratorium-studies het aangetoon dat doeltreffende krampwerende *Merbentyl*-dosisse slegs een-vyf-en-dertigste van die anti-speekseldrywende effek en een-viftigste van die pupilverwydingseffek van ooreenstemmende dosisse atropien het.

Kliniese ondervinding het bewys dat *Merbentyl* selde benewelde gesig, 'n droë mond, urine-inhouding of 'n harteffek het. Selfs dosisse wat talle kere groter as die gewone mondelinge kliniese dosis was, het geen pupilverwydingseffek gehad nie. Gevolglik is daar tot die slotsom geraak dat *Merbentyl* veilig selfs in gevalle van glaukoom is.

Indikasies: Vinnige en opvallende verligting van krampbyn is verky in 'n verskeidenheid van funksionele maagdermkwale.

Merbentyl word aangedui vir die behandeling van toestande waarby kramp van die gladde spier en hipertonus betrokke is:

Portierkramp;

Die prikkelbare dikdersmsindroom;

Babakoliek;

Galdiskinesie;

Krampagtige hardlywigheid.

Kindergeneeskunde: Voorstelbare resultate is behaal in gevalle van koliek by babetjies, die opbring van voedsel, en portierkramp. Koliek en krampbyn word vinnig verlig sonder enige opwelling van bloed, koers of ander belladonna-agtige newe-effekte.

'n Spesiale stroop met 'n aangename smaak is beskikbaar vir kindergeneeskunde.

Besikbaarstelling: *Merbentyl* is verkybaar in gerieflike dosisvorms vir pasiënte van alle ouderdomme.

Gewone *Merbentyl*-tablette, en *Merbentyl*-tablette met fenobarbitoon (bottels van 50 en 250)—elke gewone *Merbentyl*-tablette bevat 10 mg. disiklomienhidrochloried; iedere *Merbentyl*-tablette met fenobarbitoon bevat 10 mg. disiklomienhidrochloried plus 15 mg. fenobarbitoon.

Gewone *Merbentyl*-stroop (bottels van 4 ons) en *Merbentyl*-stroop met fenobarbitoon (bottels van 4 ons)—iedere teelepel gewone *Merbentyl*-stroop bevat 10 mg. disiklomienhidrochloried; iedere teelepel vol *Merbentyl*-stroop met fenobarbitoon bevat 10 mg. disiklomienhidrochloried plus 15 mg. fenobarbitoon.

Dosis: *Merbentyl*-tablette of -stroop, gewoon en met fenobarbitoon—

Volwasenes: 2 tablete of 2 teelepels vol stroop t.i.d. vóór en ná maaltye. Herhaal, indien nodig, met slapenstryd.

Babietjes: $\frac{1}{2}$ - tot 1 teelepel vol stroop tien tot vyftien minute voor iedere voeding. Nie meer as vier (4) dosisse moet binne 'n tydperk van 24 uur toegediend word nie. Verdun stroop met gelyke dele water vir suigelinge wat nog nie twee weke oud is nie.

Vervaardiging: Onder beheer van die Wm. S. Merrell Company, Cincinnati, V.S.A.

Bemark in Suid-Afrika deur: Mer-National Laboratories (Pty.) Ltd., Posbus 4551, Johannesburg.

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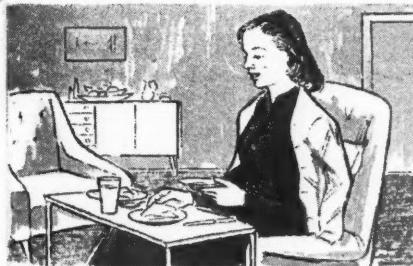
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feeds completely

as a tube-feed



as a cup drink



**as the basis of
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Complan is a *complete* food. It contains balanced amounts of *every* nutrient essential to health, in an easily digestible powder form that can be whisked, with cold or warm water, into a free-flowing mixture—eminently suitable for tube or cup feeding. What is more, Complan mixes readily with many light and digestible foods and drinks, providing tempting fare that's full of nourishment.

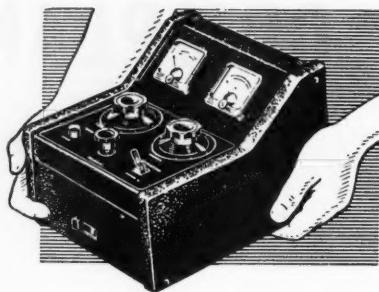
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Trade Mark



GLAXO LABORATORIES (S.A.) (PTY.) LTD., P.O. Box 485, Germiston, Transvaal.

WATSON Type MX-2
now has
LIGHTWEIGHT CONTROL



The exceptional performance of the MX-2 and its ability to produce fine radiographs under the most adverse conditions, are well known. The weight of the control unit also is well known to many who have had the misfortune to have to lift it!

Now, by reducing the range of voltages on which the unit will work, but without any loss of output, the weight of the control has been reduced to twenty pounds! The illustration at the left shows the control attached by a removable bracket to the tube-column thereby forming a completely self-contained unit which can be wheeled through the wards in one piece. When required, it can be taken apart and packed neatly into its carrying cases.

A light tubular steel support for the control unit is also supplied for surgery or bedside use. (Output of the MX-2 is 80 kVp at 15 mA. Screening is continuous at 3 mA up to 20 minutes.)

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THE BRITISH GENERAL ELECTRIC CO. OF CENTRAL AFRICA LTD.		
Box 1070, Bulawayo	Representing	Box 845, Salisbury
THE GENERAL ELECTRIC CO. LTD. OF ENGLAND		



VERSTELBARE ORTOPEDIESE TOESTELLE

Medical Distributors (Pty.) Ltd. bied met genoë aan 'Konsentriese Teleskopiese Verstelbare Orthopediese Toestelle,' vervaardig deur die Concentric Manufacturing Company, van Groot-Brittannie.

Krukke (skouer-) van volle lengte, elmboogkrukke en wandelstokke maak deel van hierdie reeks uit. Hulle is vervaardig van 'n hoogs trekbare aluminium-allooi wat lig en bykans onvernietigbaar is. Die buise het 'n 12-duim-verstellingsbestek deur middel van veerbelaste dompelaars wat dit moontlik maak om hulle by verskillende hoogtes aan te pas. Hulle is toegerus met hand-vatplekke van sponsrubber en gekussinge rubberbeslagringe om skok te verminder en maksimum-veiligheid en -gerief te verseker.



Die skouerkrukke is verstelbaar in albei seksies, en vir die oksels is daar sponsrubberkussinkies wat met leer oorgetrek is.

'n Spesiale kenmerk van die elmboogkrukke is die automatiese toestel om die onderarm-steunstuk in die horisontale posisie te sluit. Dit stel die pasiënt in staat om een hand vryelijk te gebruik om 'n deur oop te maak, 'n sigaret aan te steek, of om met absolute veiligheid op die krukke te rus.

Hierdie toestelle is deeglik ontwerp en stewig vervaardig. Hulle is ideale toestelle vir enige hospitaal se ongevalle- of fisioterapie-afdeling, want hulle verseker dat toestelle van presies die regte grootte aan pasiënte uitgerek kan word met minimum-vertraging en sonder dat dit nodig is om 'n groot aantal toestelle in voorraad te hou.

Om nadere inligting doen aansoek by die alleenverspreiders vir Suid-Afrika: Medical Distributors (Pty) Ltd., Posbus 3378, Johannesburg, of Posbus 3077, Kaapstad.

DOWNS-METAALANWYSER

Westdene Products (Pty) Ltd. verstrek die volgende inligting in verband met die Downs-metaalaanwyser wat deur die firma Down Bros. en Mayer & Phelps Limited vervaardig word.

Hierdie voortrefflike transistor-eenheid werk met 'n droë battery wat 300 uur lank diens lewer. Dit is draagbaar en is ewe gevoelig vir ysterhoudende en nie-ysterhoudende metale.

Gegewens: Vir die akkurate plekbeplaling van vreemde metaalvoorwerpe wat in die liggaaam vassit.

Plekvasstelling geskied met behulp van 'n proefsonde wat oor die verdagte gebied beweeg word.

Die aanwesigheid van metaal word hoorbaar deur 'n luidspreker, en sigbaar deur 'n meter aangedui.

Die apparaat is ontwerp om ysterhoudende sowel as nie-ysterhoudende metale aan te wys, en tussen hulle te onderskei.

'n Selektorskakelaar stel u in staat om die instrument te gebruik of vir gelyktydige hoorbare en sigbare aanwysing, of vir sigbare aflewing alleen.

Transistors en gedrukte draadstroombane word deurgaans gebruik.

Batterybediening, met 'n spesiale lekvrye kragbattery wat 300 uur lank werk.

Afmetings van die volledige eenheid: ongeveer 7½ duim by 6½ duim by 6 duim.

Gevoeligheid: Klein staalballetjies kan ontdek word op 'n afstand gelykstaande aan tien keer hul middelllyn.

Gedeeltelike onderhuidsnaalde, 3/16de duim lank en met 'n middellyn van 0.5 mm., kan ontdek word 1 duim vanaf die end van die proefsonde.

Ystervylsels word baie maklik aangewys.

Geelkopervoorwerpe kan ontdek word op 'n afstand gelykstaande aan een of twee keer hul eie middelllyn.

Ysterhoudende artikels binne die spil van die proefsonde word maklik aangedui op 'n groter afstand as wat hierbo genoem is.

Nie-ysterhoudende voorwerpe word makliker aangedui wanneer 'n groter oppervlakte met die end van die proefsonde ondersoek word.

Navrae: Westdene Products (Pty) Ltd., Posbus 7710, Johannesburg.

PREPARATIONS AND APPLIANCES

MERBENTYL

DOUBLE-ACTING SELECTIVE ANTISPASMODIC

Composition and Action: Merbentyl is the Merrell trade-name for dicyclomine hydrochloride (diethylaminocarbethoxybicyclohexyl).

Merbentyl is a non-narcotic synthetic compound exerting a potent, double spasmolytic effect upon the smooth muscle of the gastrointestinal tract.

Studies have shown a low toxicity without any cumulative action.

Musculotropic Action: Merbentyl resembles papaverine in that spasm is relieved by direct relaxation of smooth muscle. It is however non-narcotic, being unrelated to the opium alkaloids.

Neurotropic Action: Merbentyl selectively blocks the action of acetylcholine at the postganglionic parasympathetic nerve endings. This anticholinergic effect is confined to the smooth muscle of the gastro-

intestinal tract, there being no effect upon the nervous pathways, which innervate other organs.

Merbentyl has virtually no effect upon gastric secretion.

Advantages: Because of its selective dual spasmolytic action, *Merbentyl* virtually eliminates unwanted side effects. Laboratory studies show that effective antispasmodic doses of *Merbentyl* have only 1/35th of the antispasmodic effect and 1/50th of the mydriatic effect of equivalent doses of atropine.

Clinical experience has proved that *Merbentyl* rarely produced blurred vision, dry mouth, urinary retention or cardiac effects. In doses many times the usual oral clinical dose, no mydriatic effect was produced, resulting in the conclusion that *Merbentyl* is safe even in glaucoma.

Indications: Prompt and striking relief from spasm pain has been obtained in a variety of functional gastrointestinal disorders.

Merbentyl is indicated in conditions involving smooth muscle spasm and hypertonicity:

- Pylorospasm;
- Irritable colon syndrome;
- Infant colic;
- Biliary dyskinesia;
- Spastic constipation.

Paediatrics: Excellent results have been obtained in infant colic, regurgitation, pylorospasm. Colic and spasm pain is rapidly relieved without flushing, fever and other belladonna-like side effects.

A special pleasant tasting syrup is available for paediatric use.

Supplied: *Merbentyl* is available in convenient dosage forms for all ages.

Merbentyl Tablets plain and with Phenobarbitone (bottles of 50 and 250)—each tablet *Merbentyl* plain contains 10 mg. dicyclomine hydrochloride; each tablet *Merbentyl* with Phenobarbitone contains 10 mg. dicyclomine hydrochloride plus 15 mg. phenobarbitone.

Merbentyl Syrup plain (4 oz. bottles) and with Phenobarbitone (4 oz. bottles)—each teaspoonful *Merbentyl* Syrup plain contains 10 mg. dicyclomine hydrochloride; each teaspoonful *Merbentyl* Syrup with Phenobarbitone contains 10 mg. dicyclomine hydrochloride plus 15 mg. phenobarbitone.

Dosage: *Merbentyl* tablets or syrup, plain and with Phenobarbitone—

Adults: 2 tablets or 2 teaspoonsfuls of syrup t.i.d. before or after meals. Repeat, if necessary, at bedtime.

Infants: $\frac{1}{2}$ to 1 teaspoonful of syrup 10 to 15 minutes before each feeding, not to exceed four (4) doses in any 24-hour period. Dilute syrup with equal parts of water for infants under two weeks of age.

Manufactured: Under the control of the Wm. S. Merrell Company, Cincinnati, U.S.A.

Marketed in South Africa by: Mer-National Laboratories (Pty.) Ltd., P.O. Box 4551, Johannesburg.

Distributed by: Westdene Products (Pty.) Ltd., P.O. Box 7710, Johannesburg.



TACE

THE UNIQUE, ORAL, FAT-STORED OESTROGEN

Composition and Action: Tace is a synthetic compound with potent oestrogenic activity. Each capsule contains 12 mg. of *Tace*, brand of chlorotrianisene (tri-para-anisyl chloroethylene) in corn oil.

Because of its distinctly different formula, *Tace* possesses a number of unique properties:

Following oral administration, it is rapidly absorbed, and partly accumulates in the body fat, from which it is liberated gradually, in ever decreasing quantities over a substantial period of time.

In animals, the pituitary enlargement, which is a characteristic result of repeated administration of other oestrogens, does not occur. Similarly, it has been proved clinically that *Tace* has no demonstrable effect on the adrenals and, unlike other oestrogens, does not produce adrenal hypertrophy or hyperactivity.

Advantages: In Climacteric Syndrome—Where the Periods have stopped but Symptoms continue. The fat storage of *Tace* produces a continuous even release of oestrogen which continues even after cessation of therapy. The prompt symptomatic relief is, therefore, prolonged and may often persist for months after *Tace* is discontinued. This has been borne out clinically by sustained vaginal cornification and reduced pituitary gonadotrophin levels.

Gradual oestrogenic release from body fat simulates natural hormonal secretion, assisting the patient to make a physiologic adaptation to a normal, symptom free postmenopausal state.

Tace brings about a restored sense of belonging, and smoothly declining oestrogen levels obviate the peak and valley effect of short acting oestrogens, thus virtually eliminating withdrawal bleeding.

In those patients where symptoms continue beyond cessation of menstruation, one short course of *Tace*—2 capsules daily for 30 days—may often hasten the postmenopausal adjustment and avoid dependence on protracted oestrogen therapy. In severe and recurrent cases, additional courses of *Tace* may be occasionally required.

Postpartum Breast Engorgement: Clinicians have reported that *Tace* is a superior oestrogen for the suppression of lactation. Fat storage and its gradual release after cessation of therapy greatly reduce recurrence of re-engorgement symptoms and virtually eliminate withdrawal bleeding.

Prostatic Carcinoma: *Tace* has provided truly satisfying and even dramatic results in the palliative treatment of prostatic carcinoma. *Tace* has achieved effective results as demonstrated by relief of pain, increase in weight and improvement in the pathological and blood pictures; in many cases this has been effected in patients where other oestrogens had failed.

Because *Tace*, unlike other oestrogens, has no demonstrable effect upon the pituitary and adrenals, the danger of androgen rebound may be averted.



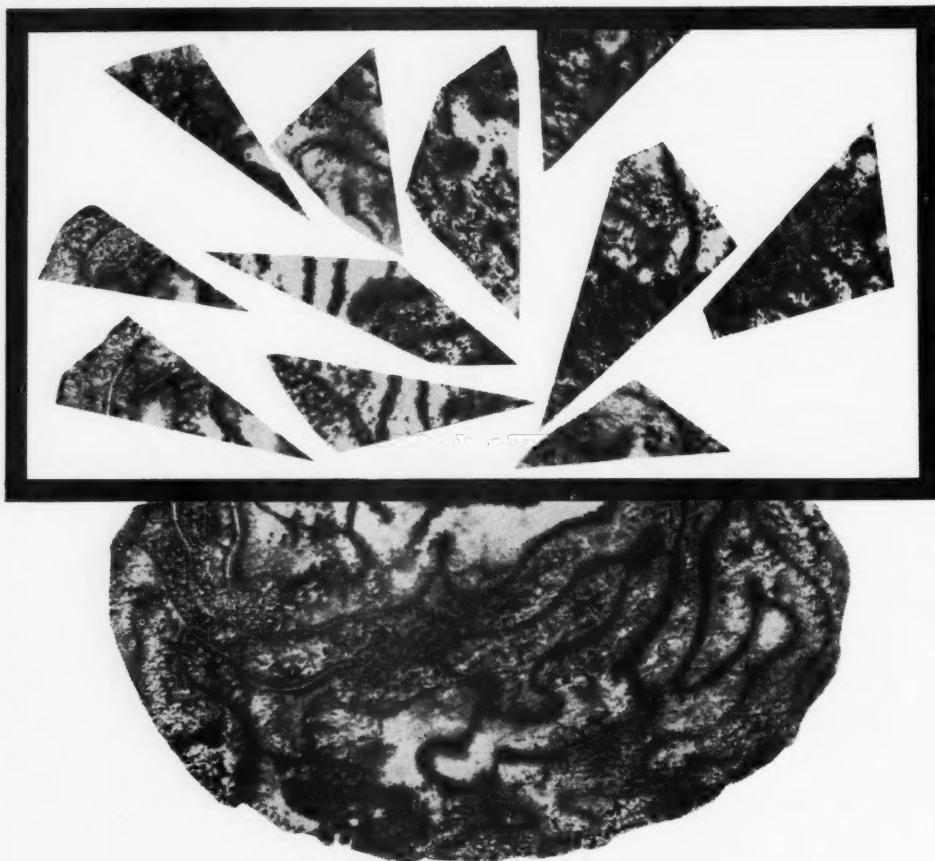


Trade Enquiries from the Sole Agents in Southern Africa:

P.O. Box 3039

FREDERICK C. MARCUS

Cape Town



to restore normal cerebral function
PARENTROVITE

PARENTROVITE is a high potency injectable preparation of the vitamin B complex with vitamin C. The formula is based on the fact that normal cerebral function depends on the oxidation of glucose and that any interference with the underlying biochemical mechanisms can cause symptoms of mental disturbance. Severe infections, burns, trauma, surgical operations, and "stresses" of all kinds can be as potent as drugs and alcohol in causing interference with the enzyme systems responsible for glucose oxidation.

To reverse such changes and to restore normal cerebral function, massive doses of the B vitamins

and ascorbic acid are needed—doses out of all proportion to normal nutritional needs. The vitamins are used here not as nutrients but as potent drugs employed pharmacologically.

The following are examples of the types of disturbance for which Parentrovite is recommended:-

Post-operative depression and confusion,
 The after-effects of influenza, pneumonia and other severe infections,
 Debility with loss of memory in old people,
 Alcoholism, acute and chronic,
 Habituation to barbiturates.

VITAMINS FROM

 **VITAMINS LIMITED**
UPPER MALL, LONDON, W.6.

KEATINGS PHARMACEUTICALS LTD.
P.O. BOX 256, Johannesburg, South Africa

Lack of adrenal activation may account for the superior effects of *Tace* over other oestrogens and the high survival rates in patients treated with *Tace*.

Besides providing prolonged around-the-clock protection, *Tace* is extremely well tolerated. Gynaecomastia, nausea and vomiting and oedema are rarely encountered.

Indications and Dosage: Relief of Menopausal Symptoms: 2 *Tace* capsules daily for 30 days. In severe cases when symptoms recur, additional courses may be required.

Postpartum Breast Engorgement: 4 *Tace* capsules daily for 7 days.

For Palliative Control of Prostatic Carcinoma: 1 or 2 *Tace* capsules daily.

Note: Gradual release from fat depots makes *Tace* especially valuable in the climacteric patient whose periods have ceased. Relative freedom from withdrawal bleeding with *Tace* precludes its use in cases where oestrogens are required to induce cyclical bleeding.

Supplied: Bottles of 60, and 300. Each capsule containing 12 mg. of *Tace* (chlorotrianisene).

Manufactured: Under the control of the Wm. S. Merrell Company, Cincinnati, U.S.A.

Marketed in South Africa by: Mer-National Laboratories (Pty.) Ltd., P.O. Box 4551, Johannesburg.

Distributed by: Westdene Products (Pty.) Ltd., P.O. Box 7710, Johannesburg.

ADJUSTABLE ORTHOPAEDIC APPLIANCES

Medical Distributors (Pty) Ltd. have pleasure in presenting 'Concentric Telescopic Adjustable Orthopaedic Appliances', manufactured by the Concentric Manufacturing Company of Great Britain.

This range includes full length (shoulder) crutches, elbow crutches and walking sticks. They are made



of a high tensile aluminium alloy, which is light and almost indestructible. The tubes have a 12 inch range of adjustment by means of spring-loaded plungers, to suit different heights. They are fitted with sponge rubber hand grips and cushioned rubber ferrules to reduce shock and ensure maximum safety and comfort.

The shoulder crutches are adjustable in both sections and have sponge rubber leather covered pads for the axilla.

The special feature of the elbow crutches is the automatic device for locking the fore-arm rest in the horizontal position. This permits the patient to have a free hand to open a door, or light a cigarette, or to rest on the crutches in absolute safety.

These appliances are well designed and of sound manufacture. They are ideal accessories for any hospital casualty or physiotherapy department to ensure that patients can be issued with the appropriate size with the minimum delay and without the necessity of a large stock.

For further information apply to the sole South African distributors: Medical Distributors (Pty) Ltd., P.O. Box 3378, Johannesburg, or P.O. Box 3077, Cape Town.

DOWNS METAL LOCATOR

Westdene Products (Pty) Ltd. announce the following information about the Downs Metal Locator, manufactured by Messrs. Down Bros. and Mayer and Phelps Limited.

This outstanding transistor unit operates on a dry battery which will give 300 hours service. It is portable and is equally sensitive to both ferrous and non-ferrous metals.

Data: For accurate location of metallic foreign bodies embedded in the body.

Location is carried out by a search probe which is passed over the suspected area.

Presence of metal is indicated audibly by a loud-speaker and visibly by a meter.

Apparatus is designed to detect and differentiate between ferrous and non-ferrous metals.

Selector switch enables the instrument to be used either for simultaneous audible and visual indication, or visual reading only.

Transistors and printed wire circuits used throughout.

Battery operated with special leak-proof power battery of 300 working hours.

Dimensions of complete unit approximately 7½ inches by 6½ inches by 6 inches.

Sensitivity: Small steel balls can be detected at a distance ten times their diameter.

Portions of hypodermic needles 3/16 inch long by 0.5 mm. diameter can be detected 1 inch from the probe end.

Iron filings can also be most readily detected.

Brass objects can be detected at a distance of one to two times their diameter.

Ferrous articles in the axis of the probe are more readily detected at a greater distance than the figure stated.

Non-ferrous articles are more readily detected when a greater surface area is presented to the probe end.

Enquiries: Westdene Products (Pty) Ltd., P.O. Box 7710, Johannesburg.

THE SOUTH AFRICAN MEDICAL AND DENTAL COUNCIL

ELECTION RESULTS

It is hereby notified that at an election of members of the South African Medical and Dental Council for the 5 years ending 31 December 1963, held in accordance with the provisions of the Medical, Dental and Pharmacy Act, 1928, as amended, the number of votes appearing below were recorded for the respective candidates:—

MEDICAL PRACTITIONERS

Black, James	1,803
Bloom, Arthur	1,277
Blumberg, Harry Israel	594
Braun, Loswel Israel Braude	1,131
Bremer, Julius Karl	1,720
Broomberg, Aaron	894
Cluver, Eustace Henry	1,952
De Villiers, Beck	1,419
Freed, Louis Franklin	811
Grant-Whyte, Harry	1,702
Impey, Robert Lancelot	1,628
Radford, Aubrey	1,751
Schaffer, Rudolph	1,424
Schepers, Gerrit Willem	1,129
Shapiro, Charles	1,367
Shapiro, Maurice	1,494
Sichel, Alan William Stuart	1,521
Tonkin, Michael Edmund Lee	1,156
Troskie, George Frederick Christiaan	1,230
Turton, Edwin Wilberforce	1,180
Vercueil, Leon Olivier	1,551
Wagner, Philipp Frederick Henry	1,540

DENTISTS

Breyer, Jan Hendrik	127
De Villiers, John Frederick van de Sandt	566
Du Plessis, Johannes Jeremias	725
Hofmeyr, Roland	722
Louw, Hendrik Hendriksz	127
Stegmann, Johannes Augustus	724

I declare the following to have been elected as members of the Council for the period 1 January 1959, to 31 December 1963:

MEDICAL PRACTITIONERS

Black, James	Johannesburg
Bremer, Julius Karl	Pretoria
Cluver, Eustace Henry	Johannesburg
De Villiers, Beck	Bloemfontein
Grant-Whyte, Harry	Durban
Impey, Robert Lancelot	Cape Town
Radford, Aubrey	Durban
Sichel, Alan William Stuart	Cape Town
Vercueil, Leon Olivier	Florida
Wagner, Philipp Frederick Henry	East London

DENTISTS

De Villiers, John Frederick van de Sandt	Umtentweni, Natal
Du Plessis, Johannes Jeremias	Johannesburg
Hofmeyr, Roland	Cape Town
Stegmann, Johannes Augustus	Bloemfontein

Wm. Impey,
Returning Officer.

Pretoria,
19 December, 1958.

CORRESPONDENCE

NORISTAN BURSARIES

To the Editor: Noristan Laboratories (Pty) Limited have made available, annually, four bursaries to the value of £120 each, to assist final year medical students (Union nationals) of the Universities of Cape Town, Pretoria, Stellenbosch and Witwatersrand, to complete their courses.

RULES GOVERNING THE BURSARIES AWARDED BY NORISTAN LABORATORIES (PTY) LTD., SILVERTON PRETORIA

- Noristan Laboratories (Pty) Limited will make available annually bursaries to assist final year medical students of Cape Town, Pretoria, Stellenbosch and Witwatersrand Universities to complete their courses.
- Four bursaries to the value of £120 each will be awarded annually to Union Nationals.
- Awards will be made by a Selection Committee appointed by the Board of Directors of Noristan Limited.
- Applications are to be submitted in writing to Noristan Laboratories (Pty) Ltd., P.O. Box 78, Silverton, Pretoria, through the Dean of the Medical Faculty of the University concerned on a form prescribed, on or before the 30th day of November in each year.

5. Applications are to be accompanied by a recommendation from the Dean of the University's Medical Faculty.

6. In making its selection, the Committee will take into account not only scholastic qualifications, but also financial requirements of the applicant.

7. The bursary will be paid to the successful applicants in equal instalments quarterly, but the arrangement can, with the approval of the Committee, be varied.

8. The decision of the Selection Committee in all matters affecting the bursaries will be final and no correspondence will be entered into in connection with such decision.

Applications should normally be submitted on or before 30 November in each year. This time, however, the closing date has been extended to 31 January 1959, and the awards will be made during February 1959.

The Deans of the Medical Faculties concerned have been advised, but as this information may also be of interest to your readers, we hope you will publish this letter in *Medical Proceedings*.

H. M. Snykers,
Director.
Noristan Laboratories (Pty) Limited,
Silverton, Pretoria.



**softens
hard stools
keeps stools soft**

HUMEVAC*

CAPSULES

HUMEVAC is a surface tension depressant used as an emulsifying and anticostive wetting agent which permits water to penetrate into, and be better mixed with, dehydrated faecal matter. The wetting effect permits the hard, dry faecal matter absorb water resulting in a softer and more homogeneous stool which is easily evacuated by normal peristalsis. HUMEVAC is not in itself a laxative, bulk-producer or lubricant, nor does it possess any of the disadvantages associated with laxatives.

HUMEVAC is not chemically altered or absorbed in the gastro-intestinal tract, and does not cause any local or systemic toxic side-effects.



PARKE DAVIS LABORATORIES
(PTY.) LIMITED

P.O. Box 9971, Johannesburg and at Port Elizabeth

*Regd. Trade Mark

THE SICK AFRICAN

A CLINICAL STUDY

*By Michael Gelfand, O.B.E., M.D., F.R.C.P.,
Physician, Salisbury Native Hospital, Southern Rhodesia*

THIRD SPECIALLY REVISED EDITION

Royal 8vo. Pp. 866. With Clinical, Radiological and Pathological Illustrations.
Buckram Binding with Gold Lettering. 77s. 6d. (Postage 2s. 6d.)

Publishers: Juta & Co., Ltd., Cape Town and Johannesburg.

- ★ The standard work for all practitioners who treat African patients.
- ★ An essential work for giving the student an insight into the African's attitude to his own disease.
- ★ *The Sick African* does not deal only with tropical diseases, although these do, of course, form a large part of the book. Many of the clinical manifestations of more general diseases differ markedly in the African from those in the European, and Dr. Gelfand takes special care to indicate where this is so.
- ★ 'The reason why this book has this wider scope is because of the richness of its clinical presentation, its cross-references of material, and the author's talent for writing simply on scientific subjects. Most important of all, it drives home the appalling state of disease-ridden Africa, the gross morbidity and fearful mortality among Africans everywhere'.

Medicus in The Star, 8 November 1957.

ORDER FORM To: Juta & Co. Limited,

P.O. Box 30 • Cape Town

:

P.O. Box 1010 • Johannesburg

Please forward copy/copies of *The Sick African* by M. Gelfand, price 77s. 6d.
(Postage 2s. 6d.)

I enclose my remittance. Kindly debit my account*.

Name

Address

* (Please delete words not required)

VOLUME V (THE AMERICAS) NOW READY

THE TIMES ATLAS OF THE WORLD

MID-CENTURY EDITION

'THE TIMES', LONDON, and the Edinburgh Geographical Institute of JOHN BARTHOLOMEW & SON, LTD. have worked together on this Mid-Century Edition of THE TIMES ATLAS OF THE WORLD.

The demand for a completely up-to-date atlas is at last met by the publication of this new edition of *The Times Atlas*, the standard to which all other atlases are compared. The present volumes, NORTHERN EUROPE, the AMERICAS, and the MEDITERRANEAN AND AFRICA are the first to appear of five uniform volumes, each covering a section of the world, each complete and independent. They measure 19½" x 12½". 120 double-page maps, each measuring 24" x 19½", will appear in the complete atlas. No effort of scholarship, cartography, engraving, or book-making has been spared to make this atlas the finest available to-day. All the plates are printed in eight colours, and the volumes are bound in heavy library cloth lettered in real gold on front and spine.

*The Atlas will comprise five volumes,
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'DISTIVIT' brand vitamin B₁₂ peptide complex, backed by clinical investigation,* is an oral preparation that is efficiently absorbed and which restores the normal blood picture in pernicious anaemia as effectively and consistently as does crystalline vitamin B₁₂ by injection. 'DISTIVIT' may be given in other B₁₂ indications including debility associated with nutritional deficiency.

* Lancet (1958), I, 982

'DISTIVIT' is an original product of DC(B)L research

PACKS

'DISTIVIT' 20

Each scored tablet contains 20 micrograms of combined vitamin B₁₂ in the form of a peptide complex.
Tubes of 25 and bottles of 100 tablets.



'DISTIVIT' 100

Each tablet contains 100 micrograms of combined vitamin B₁₂ in the form of a peptide complex.
Bottles of 100 and 500 tablets.



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123 Jeppe Street, Johannesburg

Manufactured in England by



THE DISTILLERS COMPANY (Biochemicals) LIMITED

LONDON & LIVERPOOL

owners of the trademark 'Distavit'

FPO6/88D

Stop morning sickness ‘ANCOLOXIN’^{TRADE MARK} TABLETS

Meclozine dihydrochloride 25 mg., plus pyridoxine hydrochloride (vitamin B₆) 50 mg.

“The use of a combination of meclozine dihydrochloride and pyridoxine (‘ancoloxin’ tablets) in a series of cases of nausea and vomiting of pregnancy is reported. Rapid and effective control of symptoms was obtained in all cases, some of the patients having previously failed to respond to either antihistaminic treatment alone or to pyridoxine alone.”

(PRACTITIONER, 1956 (Feb.). 176, 201)



DOSAGE

2 tablets at night. Complete relief is usually obtained within five days. Containers of 10 and 50 tablets.

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123 JEPPE STREET, JOHANNESBURG

THE PROBLEM OF EUROPEAN PROSTITUTION IN JOHANNESBURG

A Sociological Survey by Dr. Louis Franklin Freed,
(M.A., M.D., D.Phil., M.B., Ch.B., D.P.H., D.T.M. & H., D.P.M., F.R.S.S.Af.)

Chapter

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| IV | The Prostitute and Her Clients | XI | Social Control (continued) |
| V | The Prostitutes Themselves | XII | Social Control (continued) |
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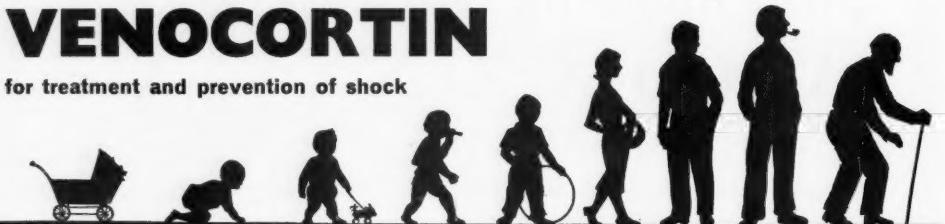
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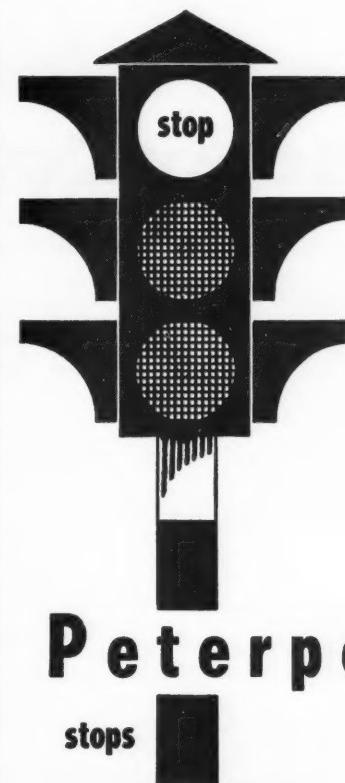
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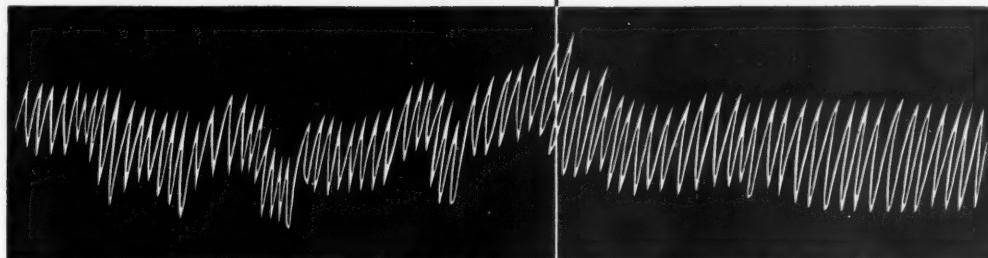
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